Jury demand | Jan. 16 [illegible] Conference | (pg. 1)

Civil & Criminal Actions

UNITED DISTRICT COURT

FOR THE SOUTHERN DISTRICT

OF NEW YORK (Filed Under SEAL)

18-CV-2575 U.S. District Court for the Southern District of New York

Pro se motion: (Motion to file compensatory, State & Federal Stand)

Plaintiff's counsel: Maurice Lemuel Tyler, 127 25th Street, N.Y., N.Y. 1000) (Jack Ryan Residence)

New federal defendants, Statement of uncontested material facts, enclosed exhibits, application for subpoena duces tecum for each defendant, motion to serve each defendant within 15 days of filing. Motion for discovery for [illegible] (counsel)

1. New federal defendants

Plethora of causes of actions

A. William "Smooth" Coleman

Last known address: North Carolina. From White Plains, NY. Mother is Doris Young.

tylermaurice11@gmail.com

I called him + asked him for money back & he texted "have you been drinking." He's called me "CRAZY" in public yet he only has a high school education. Sue for his FBI file.

347.965.2493

Automatic appeal to the United Nations

My new Business - S.M.A.R.T Skills
Maurice L. Tyler
World-Wide
Headquarters: Newburgh
[redacted] Consulting
[redacted] Trial preparation
[redacted]
People management
Mental Illness stepping (emerging)
Financial management
Motivational speaking
Personal training
International marketing

U.S. District Court
Southern District of New York

"PARA" 18-CV-2575

Fed Δ:
Medical License
Medical Malpractice
False imprisonment
Malicious prosecution
False arrest
defamation of character
Corruption
conspiracy
forced conspiracy

Civil & Criminal Action

18 Exhibit

"None of the same is wait"

(equal black & white)

Reports LinkedIn
Twitter
Stephanie-Stout

Is the race based -state-
Jealousy
Testified b/R
AOT - doesn't see me

Need patients
"Never ending patients"

Dr. Leung

Roy Black, Hugo Rodrigues "Jealousy"

Judicial Protection → Kick Back

Richmond

Greyhound Revenge Winning in
terminal
[illegible]
suicide 2009-2010

Hospital – OPD

Alcohol ↓
– liquor in the Undercut [illegible]

Dwight – runs Witness 1

Family gathering 2. [illegible]
drinks Selling

"You're jealous" Get hi

2012 Richmond

Good Pon — SEAN V. Gillis

Good Pon — Michael Andrews

Shreveport

Husband —

Cases lost's due to prosecutorial misconduct

Dominic Robinson

Dennis Bannister

NE

Tonian Douglas

Kenny Covington

Tameka Lewis

etc

(Ontear) Keshie Fernanden

Jury demand

$15 billion settlement offer

Rescinded within 30 days

from Court's order

United States District Court

Southern District Court

For New York

Order w/ ~~●~~ written reasons for judgment

Considering plaintiff's Omnibus motions and SOT requests, it is hereby ordered that the omnibus motions & SOT requests are hereby

_____.

This ___ day of ___, 2023

Please send:

_____

U.S. District Judge

Telephone

347-
965-
2493

Maurice Tyler [redacted]
tylermaurice-1@gmail.com

9:00 a.m.
Monday 2/13/23

Civil & State
Federal Complaint
Entire 18 South - Unit [redacted]

This place sucks. Nothing is done timely yet we remain in this jail. The restrictions here are overkill & lack consistency of a lawful purpose.

My "team" has done Nothing on my case yet. They [redacted] have not seen seen yet. Incompetency on a 'global' scale.

Bellevue Hospital Center
462 First Ave, New York
NY 10016 4811
Room 19 - Tel (212) 561-
4961

Jury demand (pg 2)

B. White Plains Police Department

Still hasn't produced their file on me. All of my arrests by them towards me are illegal. They are allegedly, "racist" "Corrupt", and "incompetent"

SDT for personnel file of each White Plains Police Department officer from 1995 - present. If denied, immediate appeal to U.S. 2nd Circuit, U.S. Supreme Court + United Nations. Done w/i 6 days of this motion. SERVE THESE DEFENDANTS; ITS THE LAW; IF NOT, MOTION TO remove the case to College Park Georgia. "Back pocket" of big business + drug companies.

C. All drug companies, pharmacies, and hospitals that have ever given me a pill. My body heals naturally; I do not need medicine. I've stopped drinking so much and started doing Tai Chi + isometrics. I'm not mentally ill.

Jury demand

(Pg. 3.)

I'm on disability ($1,621 monthly) & can't afford to pay expensive court costs designed to protect the "rich" & white shoe law firms. I live in a shelter because I'm unemployable due to my criminal record, mental health disorders, credit rating & lack of income.

I'm no longer going to practice law in "corrupt" "racist" Lawyers. Only the white guys & sons get the big criminal & civil cases.

I'll be taking the New York Bar within a year and doing:

- White collar criminal defense
- Major international drug cases
- High profile murder cases

Jury demand (pg. 4)

D. Jones keon Tyler my Father,
Lives at 9 Plymouth Rd,
Plymouth, Mass. From Boston,
Mass. Deadbeat "dad".
Essential to my story of innocence
all acting & comeback despite
him not give a dime growing up
& not seeing me in psychiatric
hospitals. He's bipolar I'm not.

E. All previous defendants filed
in my first lawsuit are incorporated
by reference especially Judge
Ronnie Abrams and the law
company lawyer who forced me
to plead guilty to 3 non
Felonies. They violent let the

Jury demand

(pg. 8)

represent myself, "Scam court" drugs "money" – corporate greed. Request for free transcript within 10 days of this motion

E. All pleas I've ever taken are invalid because I never had effective assistance of counsel & thus were not made knowingly, intelligently, and voluntarily.

"Scam" court run by Westchester County DA's office which hates defense attorneys.

They are a joke & abuse their vast power every day.

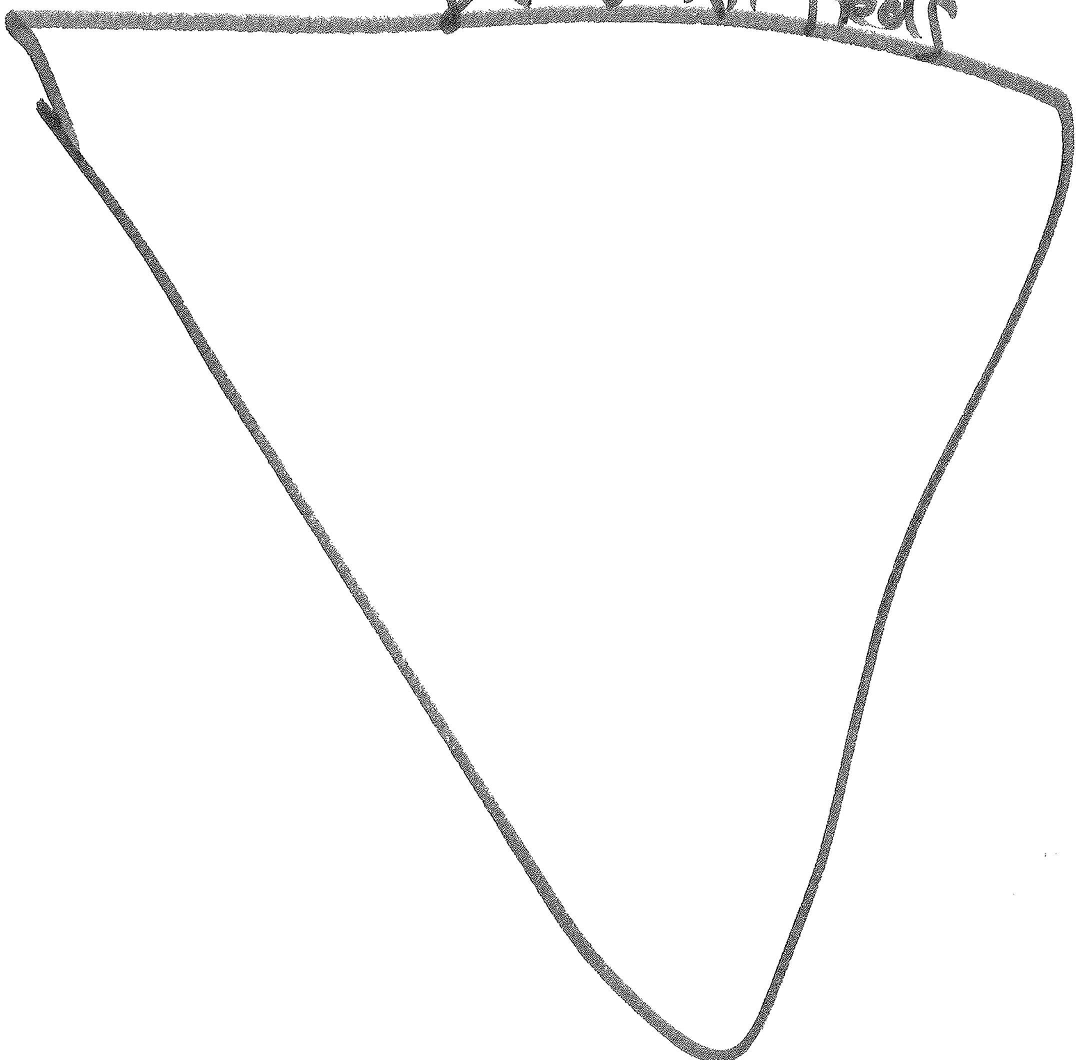
Freedom of Information Act

Brady, Giglio, Kyles, etc

F. All judges (federal & state) are involved in it as well. Why haven't these defendants been removed? Why do I have to beg for justice?

Held "hostage"
My time is valuable Sr P
block note

Danger of all needs

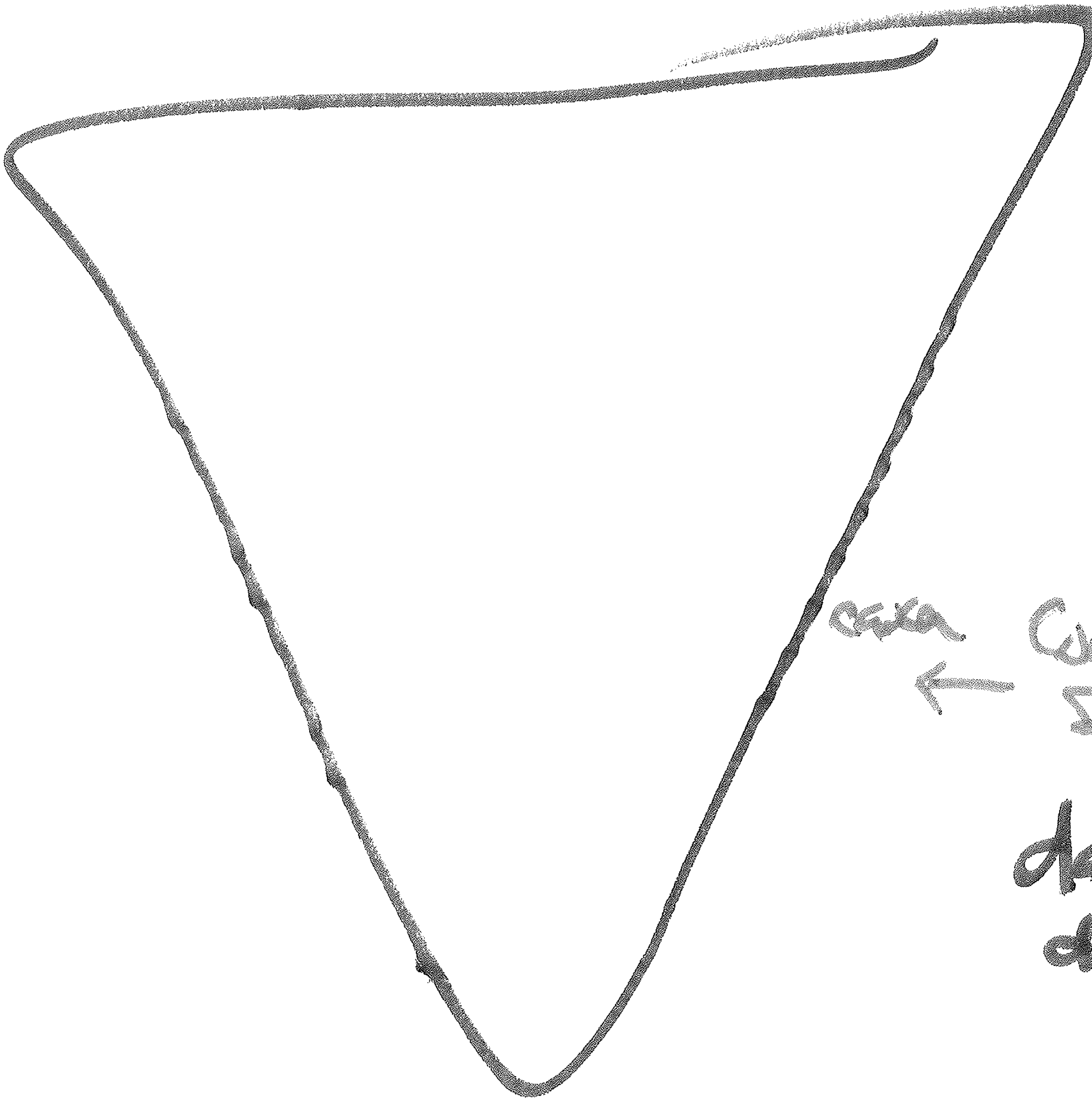


Why Necessary

Cross examination
chapters
(brief)

Psy. = [illegible] = [illegible]

Schizoaffective — Of course Not.



↓

The brain heals; God heals.

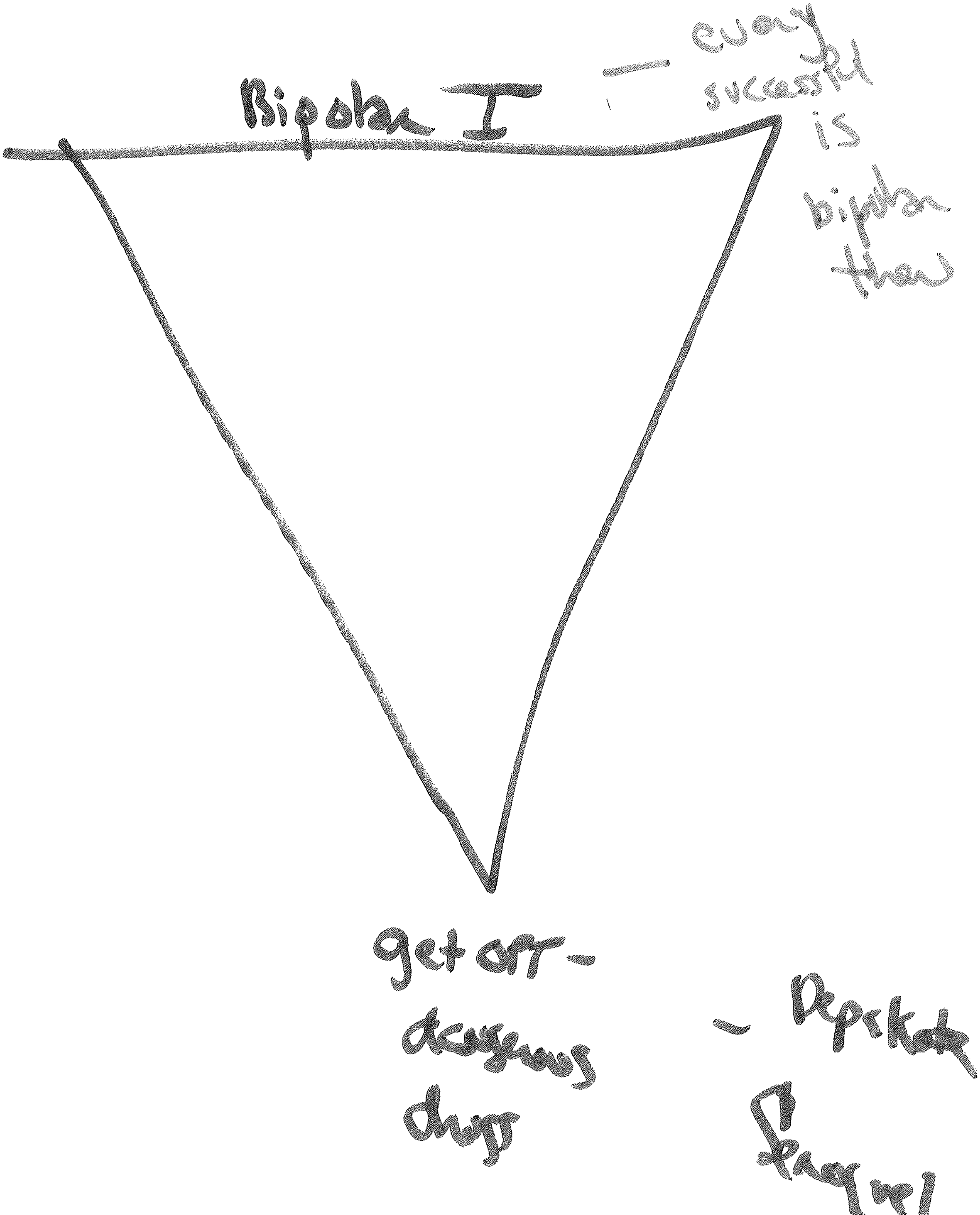
aka ← Common Sense

dangerous drugs

↓

too much sleep interaction

Can't have both both


Bipolar I
— every successful is bipolar then
get off — dangerous drugs
— Depakote Seroquel

Former [illegible]

$330 — Match budget

National ~~[illegible]~~ Accident or Association or Criminal Zone

Monell claim

Forced medication

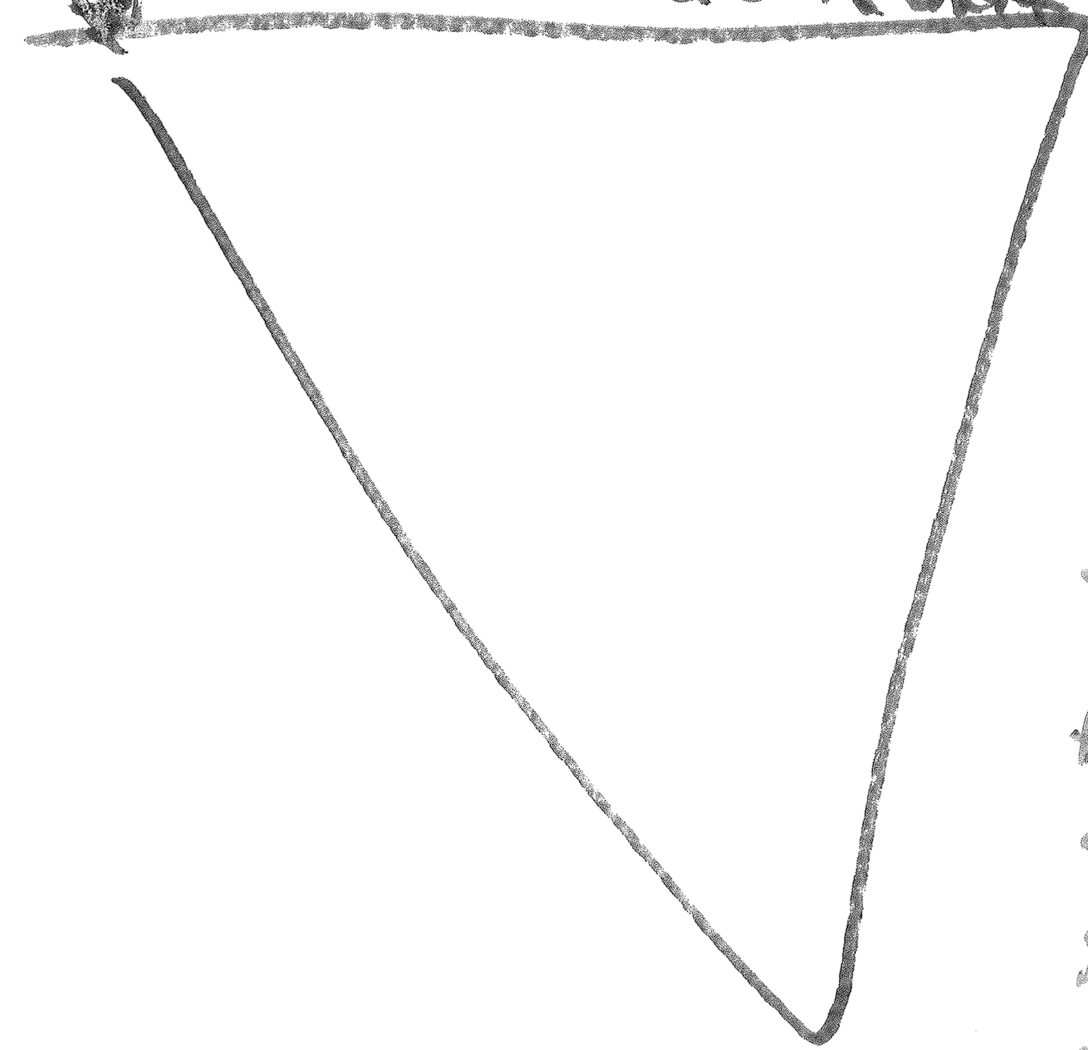
False arrest

False imprisonment

1'

2-12-23

Failure to read entire chart — Lazy doctor



Bellevue

↓

$ $ $

they are screaming to get paid

↓

Conspiracy — illegal = "Kickbacks"

↓

Corruption

Revoke all licenses
Revoke hospital license
Criminal & civil federal cou[rt]

Hospital complaint ↓ To: CEO ↓ Board of Directors

Falsely accused me of "paranoia" as a so-called "nurse". She has a major attitude problem considered this hospital officially sued in state & federal court. The federal case is already active 18-cv-2575 Maurice L. Tyler vs. White plains Police Department, et al.

Bellevue Hospital

[signature]
Maurice Lenuel Tyl[er]
Former L.A. trial
& appellate lawy[er]
127th 25th Street
New York, NY ...

Timeline #1

Beth Israel Hospital —— Competition eliminated [illegible] by Judge in

Preponderance of Evid

Not g

Spent w/P

Lawyer: Robert Joking

"Cat"

Irish Spot

Doin' Home

Games Johnson

Help → 3 days [illegible]

T-shirt

beagle "Highly

women intoxicated"

Tulane Jinglepu

2012 ↓ arrest

Newark

Birthday 11/12/11 they took to Red

2013 ↓ True Blue, Inc. Judge

"Best three except

DA: Cameron

Judge: Heaman written?

Prof. Ing (prohibited [illegible])

March mandatory expenses

1,621.00 - Disability
\+ 291.00 - SNAP

1,912.00
95.00 - SNAP

2,007.00

(Shelter)
No rent

Cell phone paid

50.00 Serv-Miss

1,957.00 U.S. District Court
500.00 - (Filing Fee)

1,457.00
407.00 - (Laptop)

1,050.00

~~500.00~~ - (~~500 Stickers~~)

~~550.00~~ ~~[illegible]~~

good feeling → mother - Jacqueline Elsine Underwood

1. Buffalo ← Likely Bipolar

born

Missed Opportunity

Familycare

my bipolar journe?

(Lithium)
Dr. Marilyn Shaw
West Jeff
Hosp. Gateway

2. 911

Missed attendance
Suicide attempt
(14)

2007

2nd Suicide attempt
White Plains Hospital & St. Vincent Hosp.

William H. Coleman Park

18 USC

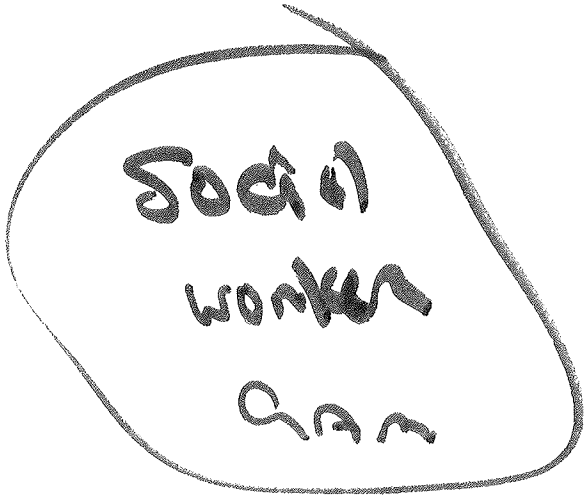
Bellevue Hosp — Federal Δ

1st Ave

New York

10016

7



N Psitetel

Shift change

to

7-8 a.m.

504-566-1600

https://www.wsj.com/articles/healthcare-deal-making-set-to-surge-in-2023-11672101417

MARKETSHEARD ON THE STREET

Healthcare Deal-Making Set to Surge in 2023

Activity has picked up in recent months, and signs point to a strong year ahead

Amgen agreed to acquire Horizon Therapeutics for $28 billion.

PHOTO: ERIC THAYER/BLOOMBERG NEWS

By David Wainer Follow

Dec. 27, 2022 7:00 am ET

This year was supposed to be a big one for healthcare deals.

On one side, you had cash-rich pharma companies staring down a $200 billion patent cliff. On the other side, you had plenty of cash-starved smaller-size biotech companies, whose valuations took a hit during the market downturn, offering discounted assets.

Yet 2022 turned out to be relatively slow. The health sector's aggregate deal value dropped 56% to $202 billion year-to-date, S&P Global Market Intelligence wrote in a report published Dec. 19.

Some of the sluggishness had to do with an imbalance in expectations. Because the stock market was so volatile in 2022 after a stellar 2021, some chief executives of target companies were hesitant to accept a valuation reset right off the bat. Meanwhile, acquirers

saw 2021 highs as ceilings, not as a realistic baseline from which to launch negotiations. Johnson & Johnson Chief Financial Officer Joseph Wolk told analysts as much during an earnings call in October, when he said that sellers hanging on to their 2021 record highs didn't make for a conducive deal-making atmosphere.

Yet that is finally starting to change, with the gap between acquirers and their targets narrowing. Soon after Mr. Wolk's comments, J&J on Nov. 1 announced one of the largest healthcare deals this year, agreeing to buy heart pump maker Abiomed for $16.6 billion in cash. The $380 price per share represented about a 50% premium over Abiomed's closing price the day before the deal was announced, but it wasn't far from the company's 52-week high set in November 2021. A similar dynamic was at play for the year's largest healthcare deal announced earlier this month: Amgen's $28 billion acquisition of Horizon Therapeutics. While the $116.50 per share reflected a nearly 50% percent premium over the closing price prior to news of the

talks, it was right around what Horizon was trading about a year ago.

The two sizable deals in the last two months of 2022 signal that the bid-to-ask spreads are starting to narrow, meaning 2023 might be a much better year for M&A. While Amgen might be tapped out given how levered it becomes after the Horizon deal, many drug and medical device companies are just getting started, with lots of balance-sheet capacity and plenty of appetite as top-selling drugs lose patent exclusivity.

Despite the Abiomed deal, J&J is expected to be a top acquirer next year. It was one of Horizon's original suitors and is widely expected to continue pursuing deals as its top-selling immunology drug Stelara loses patent protection. Another big deal maker in 2023 will likely be Pfizer. While it potentially has possibly the most deal capacity—and the biggest need given the risk to some of its product lines—Pfizer seems to be choosing to do a string of smaller acquisitions rather than a megadeal. In 2022 alone, Pfizer bought Arena for

$6.7 billion, Biohaven for $11.6 billion, Global Blood Therapeutics for $5.4 billion and ReViral for less than $1 billion. Between cash on hand and its ability to take on debt, Pfizer has more than $100 billion in additional firepower, Goldman Sachs estimates.

A megadeal could come from Merck. The company was in talks to acquire Seagen for about $40 billion before those talks hit a snag. But management has left the door open to doing a large deal as it looks to replace the expected revenue hit once Keytruda, its blockbuster cancer drug, goes off patent later this decade.

In all, next year could bring M&A deal value in the pharma and life-sciences space to somewhere in the range of $225 billion to $275 billion, PricewaterhouseCoopers wrote in a report. With so much dry powder and plenty of targets to look at, deal-making next year looks set to heat up.

Write to David Wainer at david.wainer@wsj.com

Appeared in the December 28, 2022, print edition as 'Healthcare Deals Set to Surge in 2023'.

We're hiring!

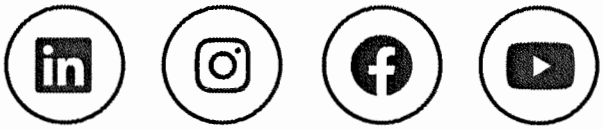
Company

Certifications

Courses

Support

Resources



Help

provider of the Financial Modeling & Valuation Analyst (FMVA)™ certification program, designed to help anyone in that role become world-class at their job. Additional resources to help you on your way include:

Free Financial Modeling Guide

Finance Interview Questions

Finance Salary Guide

Interactive Career Map

See all career resources

Share this article

4:30 pm – Circle up with the manager and review changes to the budget model as well as the board presentation.

5:30 pm – Tend to some personal errands and respond to emails from friends.

6:00 pm – Finish up changes from the 4:30 pm meeting with the manager and finalize the Excel model and PPT presentation.

7:00 pm – Head out of the office and meet some friends for dinner or head home.

Note: a day in the life can vary significantly depending on the industry, city, and the particular day. The above is meant to represent an average day for a corporate analyst. Other types of analysts, like those in investment banking, will work much longer hours.

7:00 am – At home, check phone and email for any important messages before getting ready for work and commuting to the office.

8:30 am – Arrive at the office, respond to any urgent emails, follow-up on any outstanding items from the previous day.

9:00 am – Finance team meeting to discuss changes that need to be made to the Q4-2018 budget model, including updates to assumptions and changes to forecast.

10:00 am – Work on the budget model and make all updates and changes that were discussed in the meeting.

12:30 pm – Pick up lunch from a nearby deli and eat back at the desk while catching up on financial news and videos on Bloomberg.com.

budgeted results, it's imperative to the company or the client that information be clearly presented, timely, easy to understand, accurate, and insightful. To learn more, check out CFI's Dashboards Course.

Types of Financial Analysts

Below is a list of the most common types of financial analysts:

- Investment banking analyst
- Equity research analyst
- Treasury analyst
- Financial planning and analysis (FP&A) analyst
- Private equity analyst
- Corporate development analyst

A Day in the Life of a Financial Analyst

Image from CFI's Financial Analyst Courses.

#7 Make presentations

When someone asks, *what does a financial analyst do*, the answer will always include something to do with making presentations (often in PowerPoint). The analysis that's completed in Excel then has to be turned into charts and graphs, which can then be inserted into pitchbooks and management presentations. Learn more in CFI's PowerPoint Presentations Course.

#8 Generate reports

Examples of helpful recommendations and insights include ways to cut costs, opportunities to grow revenue, ways to increase market share, operational efficiencies, customer satisfaction, and much more. This is what truly separates a world-class financial analyst from the rest. These recommendations will be presented to the CEO, the CFO, other executives, and/or the board of directors.

#6 Build Excel models

For analysts working in investment banking, equity research, corporate development, financial planning & analysis (FP&A), and other areas of corporate finance, financial modeling will be a big part of the job. These models typically start by linking the 3 financial statements and then layering on more advanced types of financial models such as discounted cash flow analysis (DCF models), internal planning models, and more arcane models such as LBO models and M&A models.

growth rates, return on equity (ROE), return on assets (ROA), debt/equity ratio, earnings per share (EPS), and many others. The analyst will look for trends and benchmark the performance against other companies in the same industry. When asking *what does a financial analyst do*, this is one of the biggest components!

#4 Make forecasts and projections

Now that historical information has been analyzed, it's time to make projects and forecasts about how the company will perform in the future. There is both an art and a science to predict how a company will perform, and many assumptions and even leaps of faith have to be made. Common forecasting methods include regression analysis, year-over-year growth rates, as well as bottom-up and top-down approaches. Learn more in CFI's Budgeting and Forecasting Course.

#5 Develop recommendations

industry research, and just about any other type of quantitative data. The information will be gathered from sources such as the company's internal databases, third-party providers such as Bloomberg or Capital IQ, and government agencies such as the Securities and Exchange Commission (SEC).

#2 Organize information

Once the data is gathered it's typically entered into Excel or some other type of database. Once inputted, the next task is to organize it, clean it up, and get it into a format it can be made sense of. This typically means sorting the numbers by data, or by category, adding formulas and functions to make sure it's dynamic, and using consistent formatting styles so that it's easy to read and understand. See more Excel formatting tips.

#3 Analyze financial results

With the data all cleaned up and organized in Excel, it's time for the financial analyst to start analyzing past

#1 Gather data and information

The work of a financial analyst starts with gathering data and information about whatever they need to

question, *what does a financial analyst do*?

To learn more about the real day-to-day life of an analyst, check out CFI's Online Financial Analyst Courses, as they provide complete training on all of the most important skills that are required for the job.

List of What a Financial Analyst Does:

Analysts have many duties and responsibilities, depending on the organization they work for, the

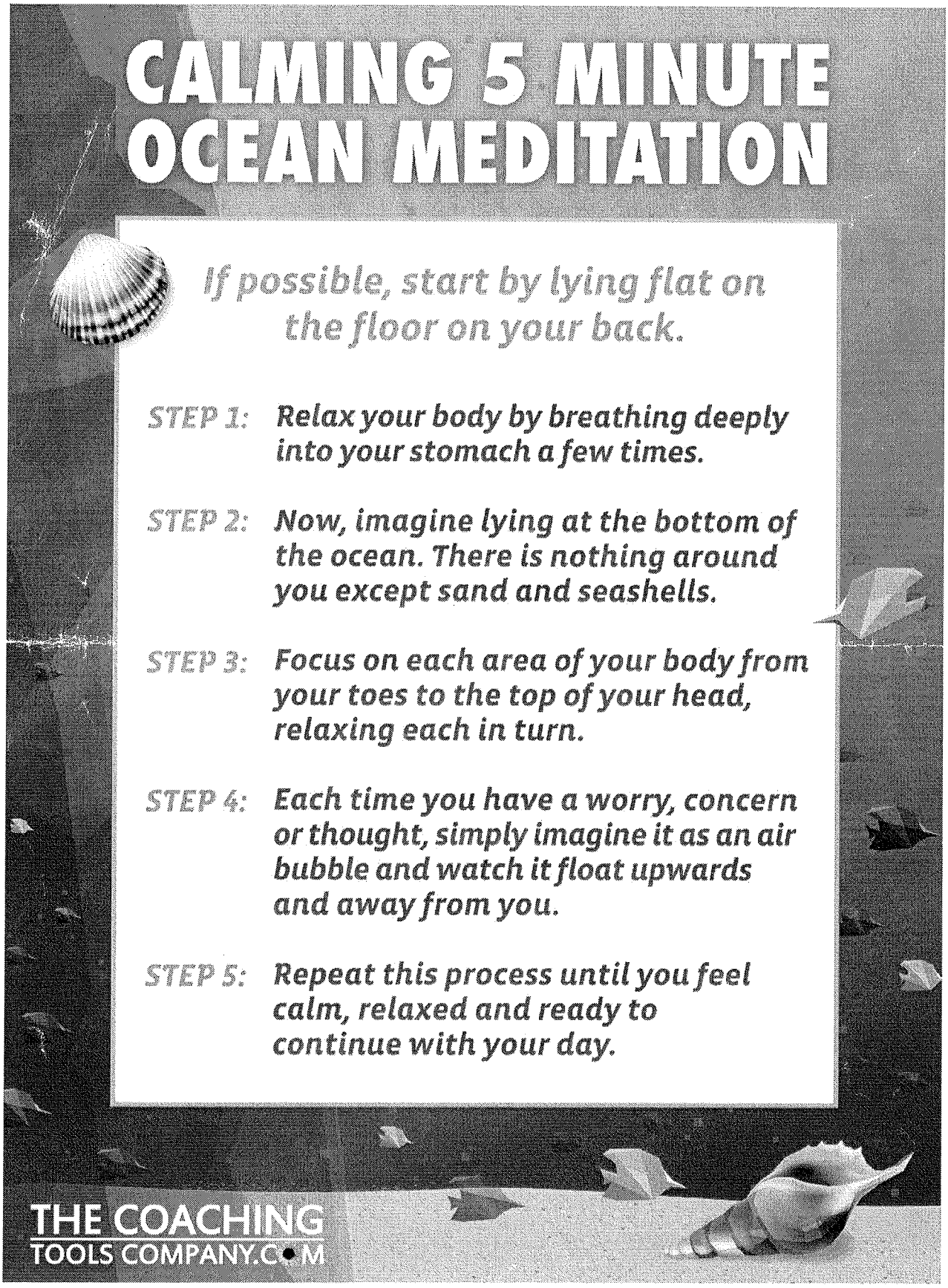
What Does a Financial Analyst Do

What the life of an analyst is really like

Written by **CFI Team**
Updated December 4, 2022

What Does a Financial Analyst Do? A Day in the Life

A financial analyst is responsible for a wide range of activities including gathering data, organizing information, analyzing historical results, making forecasts and projections, making recommendations,

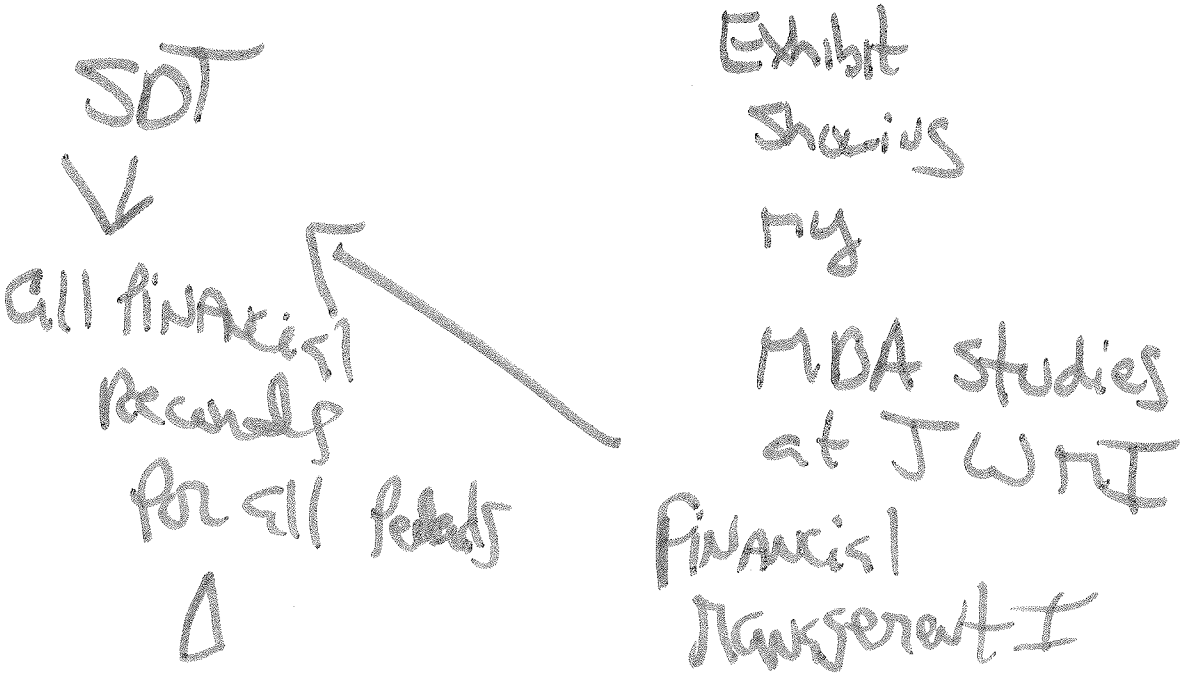

CALMING 5 MINUTE OCEAN MEDITATION
If possible, start by lying flat on the floor on your back.
STEP 1: Relax your body by breathing deeply into your stomach a few times.
STEP 2: Now, imagine lying at the bottom of the ocean. There is nothing around you except sand and seashells.
STEP 3: Focus on each area of your body from your toes to the top of your head, relaxing each in turn.
STEP 4: Each time you have a worry, concern or thought, simply imagine it as an air bubble and watch it float upwards and away from you.
STEP 5: Repeat this process until you feel calm, relaxed and ready to continue with your day.
THE COACHING TOOLS COMPANY.COM

https://www.wsj.com/articles/at-davos-mood-is-somber-as-many-ceos-question-economys-future-11673952415

BUSINESS

At Davos, Mood Is Somber as Many CEOs Question Economic Outlook

Business leaders at the World Economic Forum also see signs of hope: 'There are all kinds of shoes that could have dropped'



Politicians and top executives gather in Davos, Switzerland, for the annual World Economic Forum.

PHOTO: STEFAN WERMUTH/BLOOMBERG NEWS

By Chip Cutter Follow *and Sam Schechner* Follow

Updated Jan. 17, 2023 2:37 pm ET

DAVOS, Switzerland—The end of the free-money era has put a chill in the Swiss mountain air.

Business leaders and economists gathered here for the World Economic Forum's annual event say they see the world buffeted by high inflation—and high interest rates that central banks have pushed through to combat

it. That has created a threat of recession, and led some of the world's biggest companies to hold their breath—and their spending—ahead of an uncertain year.

Yet, some see reasons to think rising inflation, sparked in part by Russia's invasion of Ukraine, has peaked. That could, as some business leaders hope, presage a soft economic landing. Alternatively, another rise in interest rates could lead to a more prolonged downturn.

Many businesses are slashing costs—and in some cases jobs—to be prudent, several business leaders said. But a number are also holding out hope that they won't need to cut too deeply to take advantage of what some expect could be a rebound this year if major economies skirt a recession.

"The mood is somber," said Nick Studer, chief executive of the Oliver Wyman Group consulting firm, who has attended meetings in Davos for years. "At the same time, you've got a lot of people hoping that the U.S. and the U.K. environment—if it's recessionary—is either short or shallow."

Whether the U.S. dips into a recession this year remains an open question, many business leaders say. Executives have been preparing for the possibility for months, even as consumer spending has remained fairly strong and the unemployment rate stood at a historically low 3.5% in December.

"I haven't heard in 30 years being in business of people talking about the recession for so long," said Christophe Beck, chairman and CEO of Ecolab Inc., a provider of services and products used in water treatment, cleaning and infection prevention. "We will get ready for it in a way and it might not even happen."

The pessimism sparked last year by rapid interest-rate increases and expectations that would lead to a downturn might be ebbing.

Larry Summers, the former Treasury secretary, said he has become less pessimistic about the Federal Reserve's actions, and now believes that the economy is unlikely to experience massive financial trauma in the months ahead.

Davos attendees "are sort of daring to be hopeful but not entirely convinced of being hopeful," Mr. Summers said. He has predicted that to bring inflation down, a recession would be necessary. He still doesn't expect a soft landing, when growth slows but doesn't turn negative. "But it looks more plausible to me that there would be a soft landing than it did, principally because the economy is staying strong."

The world has also avoided some potential problems, such as widespread energy outages in Europe, oil prices above $150 a barrel and a new Covid variant that could cripple society, he said.

"There are all kinds of shoes that could have dropped that have not dropped," Mr. Summers said.

Gita Gopinath, first deputy managing director of the International Monetary Fund, said economic performance in both the U.S. and Europe has surprised on the upside since October, when the IMF released its last economic outlook. This has led to risks being "somewhat more balanced going into 2023," she said.

Still, she said it would take a few more wage and price-inflation reports in line with the restrained increases reported recently before "we can start feeling much more comfortable about the inflation trajectory." For now, the IMF thinks interest rates in the U.S. will remain around 5% through the year, she said.

Business leaders also are watching a handful of risks that could reset their calculus. Those include the potential for conflict between China and the U.S. over Taiwan and the possibility of an impasse in the divided U.S. Congress over raising the country's debt ceiling—threatening a U.S. government default.

Issues that caused headaches for business leaders throughout the pandemic, such as supply-chain snarls or construction delays, aren't fully resolved, either, said Stanley Bergman, CEO of dental-products supplier Henry Schein Inc.

Managing through the current economic climate is complicated by the fact that some in business have

little experience operating in periods of rising interest rates.

"If you talk to people on Wall Street who are 35 years and younger, they think it's the end of the world," Mr. Bergman said. "You talk to people 50 and over, we've been through this many times."

Wage inflation is also stabilizing, making it less of an issue than earlier in the pandemic, said Annette Clayton, CEO of North American operations at Schneider Electric SE, a Europe-headquartered energy-management and automation company. A slowdown in hiring in tech has made it easier for other companies to woo workers, she added.

"You're competing a lot less with an Amazon factory, Amazon distribution center than you were just a year ago," Ms. Clayton said.

The war in Ukraine is adding to uncertainty about the coming year.

PHOTO: KYODONEWS/ZUMA PRESS

Some see the downturn getting worse—particularly for big tech companies that grew into juggernauts in a free-money era and are pivoting to austerity and layoffs. Those companies are striking a more subdued tone at Davos this year.

Matthew Prince, CEO of cloud-infrastructure company Cloudflare Inc., said that in his conversations with clients, many say that business is slowing and that they are looking to cut costs. Cloudflare itself has slowed some hiring to weather a downturn.

"Anyone who's not nervous isn't paying attention," Mr. Prince said. "Customers are saying: These are tough times."

Still, some executives say they have underappreciated how China's reopening could help their businesses. Those with operations on the ground in China have expressed optimism to peers that results there this year could be better than forecast.

"There is without doubt a view that China will open up faster than some people anticipated," said Tim Ryan, U.S. chairman at professional-services firm PricewaterhouseCoopers LLP, who has had conversations with executives across industries in recent days.

At the same time, many executives realize that the war in Ukraine and other geopolitical issues remain out of their control. "That gets them down," Mr. Ryan said.

—Bowdeya Tweh and Greg Ip contributed to this article.

Write to Chip Cutter at chip.cutter@wsj.com and Sam Schechner at Sam.Schechner@wsj.com

https://www.wsj.com/articles/goldman-sachs-profit-plummets-from-deal-making-drought-11673960103

MARKETSFINANCE

Goldman Sachs, Morgan Stanley Profits Dented by Deal Slump

Wall Street firms also set aside more money to prepare for a potential recession

Goldman Sachs and other Wall Street deal makers are grappling with a 2022 dive in mergers and acquisitions.

PHOTO: LUCIA BURICELLI FOR THE WALL STREET JOURNAL

By AnnaMaria Andriotis Follow , *Charley Grant* Follow *and Gina Heeb* Follow

Updated Jan. 17, 2023 2:08 pm ET

Goldman Sachs Group Inc. GS -6.15% ▼ and Morgan Stanley reported sharply lower fourth-quarter profits on Tuesday, hurt by a continued slowdown in corporate deal-making that had fueled record Wall Street earnings a year earlier.

Goldman's quarterly profit fell 66% from a year ago, and Morgan Stanley's fell 40%. Both also reported lower revenue.

Goldman missed analysts' expectations for both profit and revenue. Its earnings amounted to $3.32 per share, compared with the $5.56 per share expected by analysts

polled by FactSet. It was Goldman's biggest earnings miss in years, according to FactSet.

"Simply said, our quarter was disappointing," Goldman CEO David Solomon told analysts. "These results are not what we aspire to deliver to shareholders."

The quarterly earnings cap a tough year for Wall Street deal makers. Companies flush with cash, a roaring stock market and a positive economic outlook fueled a deals boom in 2021. But M&A took a dive in 2022. Rising interest rates, inflation, Russia's war in Ukraine and concerns about a looming recession pushed many CEOs to shelve their plans to go public or buy other companies.

Investment bankers at both Goldman and Morgan Stanley saw big declines in the fees they earned from advising companies on mergers and from underwriting stock and bond offerings. Investment banking revenue fell 48% at Goldman from a year ago and 49% at Morgan Stanley.

JPMorgan Chase & Co. and Bank of America Corp. last week reported even steeper drops in investment banking fees, down by more than half at both. But those banks both have big consumer arms and are less reliant on deal making than their Wall Street-heavy counterparts. They both reported higher overall profit and revenue for the fourth quarter.

The banks all set aside more money for potential loan losses, a sign that they are preparing for an economic downturn.

Goldman executives said the bank increased rainy-day funds partly in response to existing credit-card balances. Executives also said they had slowed credit-card originations and tightened underwriting.

"When we started this business we knew and expected that a consumer business over the long term would have ups and downs over the credit cycle," Goldman finance chief Denis Coleman said in an interview. "We happen to be in a more negative part of the cycle right now."

Morgan Stanley CEO James Gorman told analysts he is highly confident that investment banking will pick up again when the Federal Reserve pauses its rate increases.

"We're not of the view that we're heading into a dark period, whatever negativity in the world is out there," Mr. Gorman said. "This thing will turn."

The economic uncertainty that was bad for investment bankers was, generally, fuel for traders. Trading revenue rose 18% at Goldman, following increases reported last week by JPMorgan, Bank of America and Citigroup Inc.

Morgan Stanley was the exception. Its trading revenue fell 12%.

Mr. Solomon is pushing his own bank to focus on steadier businesses like asset and wealth management, with Goldman just completing a reshuffling of its businesses.

Goldman is also in the process of pulling back on some of its consumer efforts. The bank last week revealed some details about the costly toll of its move into Main Street lending. On Tuesday, Goldman disclosed that its Platform Solutions unit had lost $3.8 billion on a pretax basis since the start of 2020.

That unit includes Goldman's credit-card partnerships and specialty-lender GreenSky.

"We tried to do too much too quickly," Mr. Solomon said on a call with analysts.

Fourth-quarter revenue jumped in Platform Solutions, though the year-ago results didn't include GreenSky. The bank said the unit's higher revenue was also due to consumers taking on significantly higher credit-card balances.

The company, however, emphasized the results in its wealth-management business, where revenue rose 6% and profit increased by one-third. Mr. Gorman has doubled down on wealth management throughout his

CEO tenure, emphasizing it as a ballast against the highly volatile businesses of trading and banking. Wealth management accounted for about 45% of Morgan Stanley's 2022 revenue.

Overall, Goldman turned out $1.33 billion in fourth-quarter profit, down from about $3.94 billion a year ago. Goldman's fourth-quarter revenue was $10.59 billion, down 16% from a year ago. That missed the roughly $10.76 billion expected by analysts.

Morgan Stanley's fourth-quarter profit was $2.24 billion, down from $3.7 billion a year ago. That amounted to $1.26 per share, just topping the $1.25 that Wall Street expected.

Both banks recently laid off employees, and the industry is expected to slash bonuses.

Goldman cut its 2022 compensation expense by 15%, and Morgan Stanley cut its compensation pool by 6%.

"We continue to focus on cost discipline," Goldman said in a statement. "We're looking at expenses in every corner of the firm and that will take time to be reflected in our results."

Goldman shares fell 8% in afternoon trading. Morgan Stanley shares rose 7%.

Write to AnnaMaria Andriotis at annamaria.andriotis@wsj.com

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215 W 35th ST
New York, NY 10001
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Saturday 2/11/2023 4:52 PM

Member : Invoices - ABC History

Name	Value
Member	MAURICE TYLER
Agreement Number	0003234648
ABC Account Balance Due	49.00
Total ABC Account Balance	74.03

Transaction Date	Description	Invoice Amount	Payment Applied	Balance	Reverse
02/01/2023	Late Fee as. 02/03/2023	0.00		0.00	
01/26/2023	HOLD CREDIT CARD		0.00	0.00	
01/24/2023	INVALID CREDIT CARD		0.00	0.00	
01/20/2023	ACCOUNT FROZEN		25.03	0.00	Yes
01/17/2023	DRAFT PAYMENT		-25.03	-25.03	
01/17/2023	Dues - pft ctr DIGX	0.00		0.00	
01/17/2023	Dues - pft ctr DUESWTAN	0.00		0.00	
01/17/2023	Late Fee as. 01/21/2023	0.00		0.00	
12/17/2022	DRAFT PAYMENT		-25.03	0.00	
12/17/2022	Dues - pft ctr DIGX	5.00		25.03	
12/17/2022	Dues - pft ctr DUESWTAN	20.03		20.03	

(pg.6)

Order

Considering the Foregoing, IT IS ORDERED that plaintiff's pro se motions are

by the ____, on this ____, 2023.

U.S. District Judge

Service to Plaintiff's Pro se -

Maurice L. Tyler
127 25th Street
Jackson Residence Inn
New York, New York 10001
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347-965-8493

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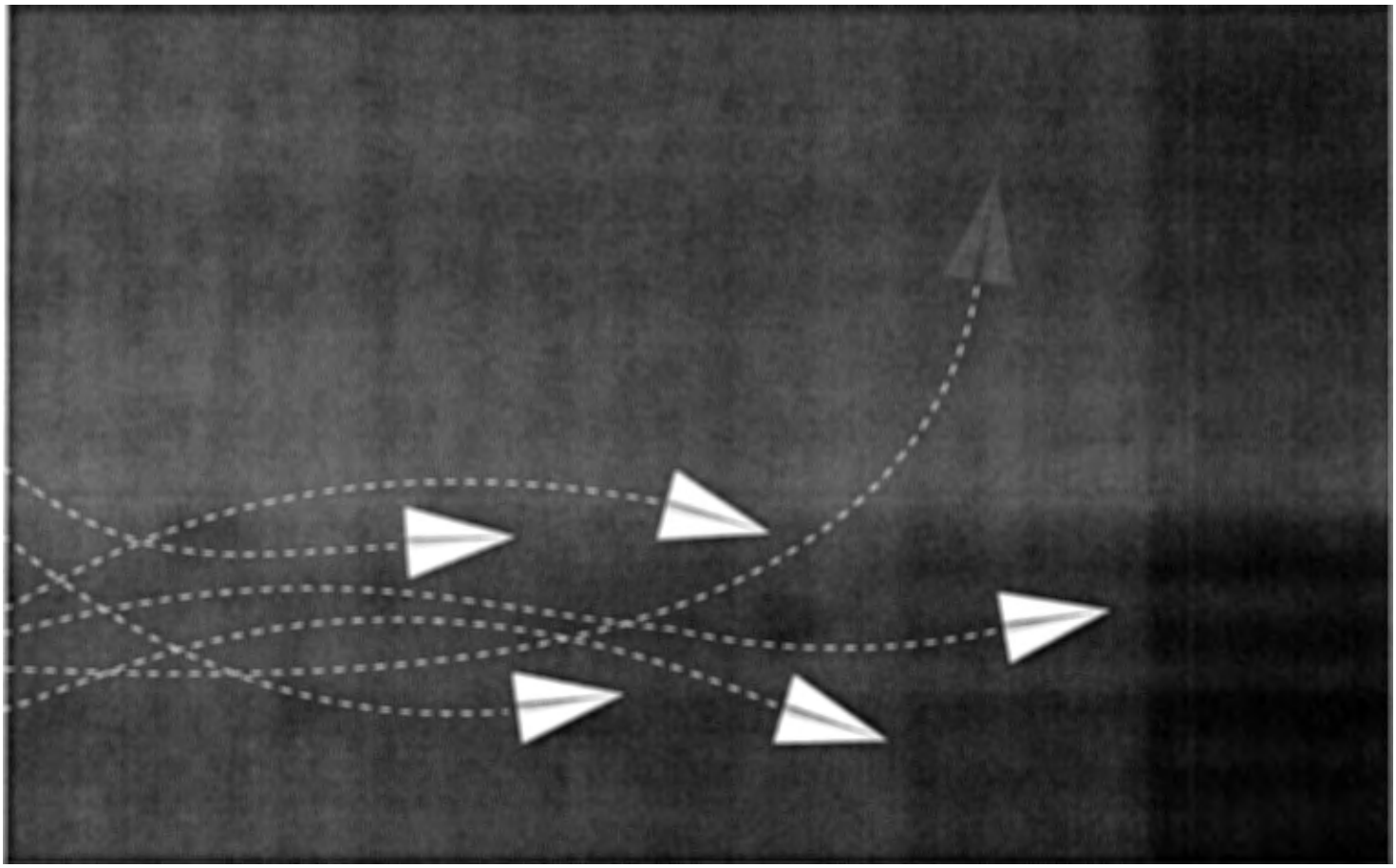


LEADERSHIP, PROJECT MANAGEMENT, TIME TRACKING

3 Tips for Rethinking your Project Planning in the New Year

At this point in the year, you are likely in the process of planning where your company is headed in 2023. Whether you've been

Exhibit I
I've been told by all but except MOA email to dean snail

Review your vision and mission statement.

As your view of yourself and the future changes, it is important that you review, update and refine your vision and mission statement at least once every six months. If you feel really inspired, you may even want to expand it with more detail and turn it into a personal development plan. So get scribbling and imagine how nice it will be to start out in January with a clear roadmap for where you want to go

- Imagine that you are managing and leading the project of your dreams. Envision that everything is exactly the way you want it to be: the type of project you are running, the industry it is in, its size and complexity, the people involved, and your own capabilities as a project manager and leader. Imagine that you are every bit as successful as you want to be. Feel it and see it.
- Keep imagining yourself in the future, and be as specific as possible in your observations. Where exactly are you? Who is your client? What are you doing? Who are you interfacing with? What does the project look like? How big is it? How are you feeling? Why do you want to be exactly where you are? What is the bigger impact you are having?
- Draw a picture of yourself and your surroundings five years from now. Draw the elements you see, feel, and hear. Use as many colors as you want and be as detailed as possible.

Step 3: Sum up your vision and mission.

- Write to the following questions: How can you sum up your vision and mission as a project manager? What are the things you ultimately want to achieve? Who do you want to be? What do you want to do? What is the ***impact*** you would like to have and how would you like to be perceived?
- What will need to happen in order for you to feel proud of your progress as a project manager in five years' time?

living up to these values.

Ideally, the vision and mission statement should also be aligned with the values, culture and possibilities of the organization you currently work for. If your personal values and aspirations are being matched by your employer's, it will be much easier to progress and fulfill your dreams.

However, if your goals are far beyond what the firm can offer, you will need to be honest and assess if the job is still a good match for you. With a strong vision and mission statement, it's easier for you to evaluate in which industry and company you should invest your time and energy.

So, how do I go about writing it? What are the steps?

When composing your own statement, find a quiet place where you feel at ease and where you will not be interrupted. Then follow the below steps and guiding questions.

Mission statement:

- A mission statement describes what you want *now* and *how* you will achieve your long term aspiration.
- A mission statement does not define a long term future state but is more concerned with the present state. It answers the questions of: *"What do I do?", "How do I do it?", "Who do I do it for?", "What makes me different"*, and *"What is the benefit?"*
- It talks about the present leading to the future, and how you will get to where you want to be.

Example: *"My mission is to help project managers transform into impactful project leaders."*

In order to get the most value from this exercise I suggest you combine the two into a vision *and* mission statement. Define the overall essence of what you want to achieve and then look at what you are doing to achieve it.

What makes a good vision and mission statement?

- A good vision and mission statement is concise and inspirational.
- It's easy to memorize and repeat.
- It should be clear, engaging, and realistic, and describe a bright future.

Everyone's will look and sound completely different. It's important that it encapsulates *your* values and aspirations, and that it makes you feel really good and inspired when you read it aloud.

How does a vision statement differ from a mission statement?

Vision and mission statements are very similar but they have their differences. Let's take a deeper look:

Vision statement:

- A vision statement describes what you want to achieve in the *future*.
- The vision statement answers the question *"Where do I want to be?"*
- It defines the optimal desired future state—the mental picture—of what you want to achieve over time, say in five, ten or more years.

Setting goals and making resolutions; out with the old, in with the new—some of us get downright busy charting our ambitions for a fresh year. But have you thought about writing your own personal vision and mission statement? We asked Project Manager Coach Susanne Madsen how to create a powerful and sustainable mission and vision statement to take us into the New Year.

What is a vision and mission statement?

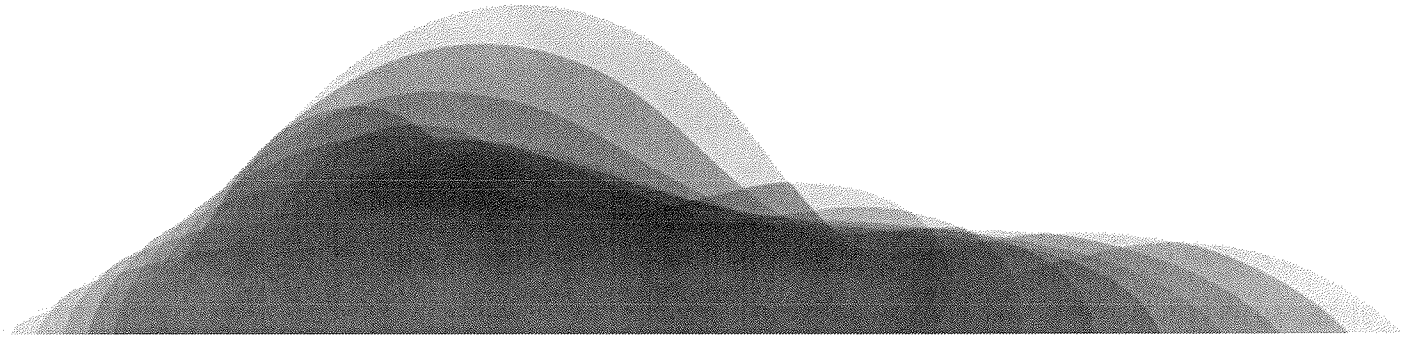
A vision and mission statement is a paragraph that encapsulates everything you would like to be, do, and have in your career.

It defines what success and excellence look like to you. It expresses your vision for where you want to be in the future and it reflects your values, goals, and purpose and how you want to operate.

Can you give an example of one?

Tips, stories, and insights to better manage work, improve productivity and enhance collaboration.

Email* SUBSCRIBE



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LIQUIDPLANNER, PROJECT MANAGEMENT

How to Create a Personal Mission and Vision Statement for the Year

If you never had to work another day in your life, how would you spend your time?

When your life is ending, what will you regret not doing, seeing, or achieving?

What weaknesses have others noticed about you? What do you believe are your weaknesses?

What strengths have others seen in you based on your personality and accomplishments? What strengths do you see in yourself?

CRAFT YOUR PERSONAL VISION STATEMENT

Once you have thoughtfully prepared answers to these questions and others that you identify, you are ready to craft your personal vision statement. Write in the first person and make statements about the future you hope to achieve. Write the statements as if you are already making them happen in your life. Some experts recommend keeping your vision statements 50 words or less, but it is more useful to fully articulate the vision you want for your life and your future, rather limiting yourself by the word count.

My Personal Vision Statement:

Worksheet adapted from www.personalsuccessinsight.com

Developing a Personal Vision Statement

Ex. 10

What are the ten things you most enjoy doing? Be honest. These are ten things without which your weeks, months, and years would feel incomplete.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What three things must you do every single day to feel fulfilled?

1. _____
2. _____
3. _____

What are your five or six most important values?

Value Examples: Accomplishment, Accountability, Accuracy, Ambition, Challenge, Collaboration, Competency, Courage, Credibility, Dedication, Dependability, Dignity, Diversity, Efficiency, Empathy, Empowerment, Enjoyment/Fun, Equality, Excellence, Flexibility, Honesty, Improvement, Independence, Individuality, Innovativeness, Integrity, Loyalty, Optimism, Persistency, Quality, Respect, Responsibility, Security, Service, Stewardship, Teamwork, Wisdom.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Your life has six important dimensions, all of which deserve some attention in your personal vision statement. Write one important goal for each category:

Educational/Intellectual: _____

Family/Home: _____

Financial/Career _____

Health/Physical _____

Social/Cultural _____

Spiritual/Religious _____

04. Inspiring

Your vision statement should align with your company standards and values and be integrated into your company culture. You'll want it to motivate your employees and be something they look to for inspiration. To do this, you'll need to make sure that your employees are aware of the company vision in the first place. Make sure to review the vision statement during orientation or even hold employee workshops. You can have employees brainstorm ways they can incorporate the company vision throughout their work days.

Talia Cohen
Small Business Expert and Marketing Blogger

You can see that each company's vision statement contains goals for the future. The idea is to always have a greater purpose to strive for, providing the company with direction and motivation.

What makes a good vision statement?

While you may think that writing a vision statement is simple, it actually takes quite a bit of finesse to create one. Your vision statement should be:

01. Simple

Your vision statement should be one to three sentences long. While you can choose to elaborate on it in a more detailed vision statement document, your vision statement itself should be punchy and to the point. It's also best not to include buzzwords that only add fluff, such as "amazing," or "premiere." Also, avoid industry jargon so your statement is clear and understandable to those both in and outside the company.

02. Personal

Your vision statement should relate directly to what your company sells or does. A vague statement such as, "We aim to increase our number of shareholders by increasing revenue," is a substantial goal, but doesn't belong in your vision statement. It should project how your business is going to improve the lives of your customers.

03. Achievable

While we would never knock ambition, you don't want your vision statement to be unattainable. A statement like, "Our vision is that every person in the world will use our product," isn't realistic (but what an amazing triumph that would be). Dream big, the best companies do. But don't create exaggerated goals that your business can't possibly achieve.

Google

Mission: To organize the world's information and make it universally accessible and useful.

Vision: To provide access to the world's information in one click.

NIKE

Mission: To do everything possible to expand human potential. We do that by creating groundbreaking sport innovations, by making our products more sustainably, by building a creative and diverse global team and by making a positive impact in communities where we live and work.

Vision: To bring inspiration and innovation to every athlete in the world.

Uber

Mission: Uber's mission is to bring transportation - for everyone, everywhere.

Vision: Smarter transportation with fewer cars and greater access. Transportation that's safer, cheaper, and more reliable; transportation that creates more job opportunities and higher incomes for drivers.

amazon

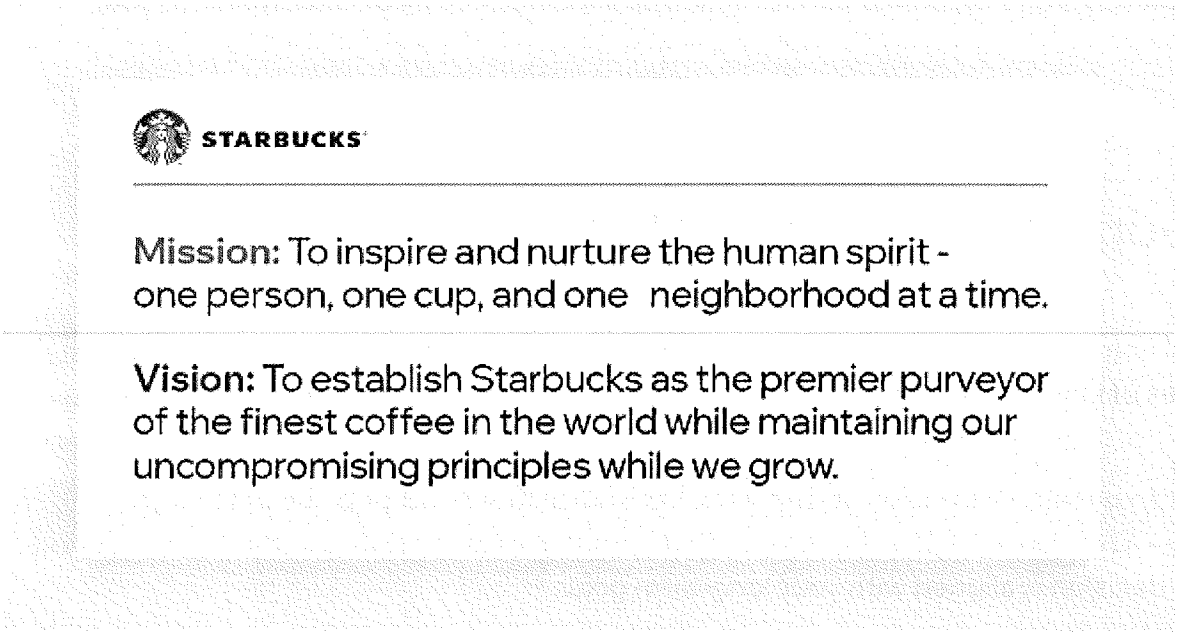
Mission: We strive to offer our customers the lowest possible prices, the best available selection, and the utmost convenience.

Vision: To be Earth's most customer-centric company, where customers can find and discover anything they might want to buy online.

This is an excellent question, and the answer is no.

While the two work together to mold the future of a business and shape company culture, there are distinct differences. Unlike a vision statement, a mission statement focuses on the present. A mission statement focuses on the immediate goals of a business and what it's doing to achieve them. It should consider questions like, *What do we do?* and *How do we do it?* while vision statements consider questions such as, *What are we striving to achieve overall?* and *What is our long-term goal?*

To give you a better idea of the differences between the two, here are five excellent mission statement examples and their vision statement counterparts from top US brands:



- Become
- Transform
- Supply
- Cater
- Improve

In our insurance company example, we use the word “provide” to show action. This helps all stakeholders understand that your vision statement isn't just a vague assertion, but that your company is actively moving toward achieving these goals. When crafting your own vision statement, consider which action words best align with your goals. That way, you’ll be on the path to solidifying the perfect vision statement for your brand.

What is the purpose of a vision statement?

A vision statement is a living declaration that is part of a company’s overall strategic plan. It is typically written in the early stages of starting a business and helps steer the company in the intended direction.

All types of businesses can benefit from vision statements, from small mom-and-pop shops to large corporations. It should be a reference tool to help ensure that your business is moving in the right direction and that every business decision is aligned with your long-term goals.

A well-written vision statement should motivate, excite and inspire. It should outline the future of your organization for all stakeholders, from investors to employees, and should be a core part of your corporate culture. It should also provide your employees (and potential future employees) a reason to wake up every day and continue working hard for the company.

In fact, according to a study of over 50,000 employees, those who found the vision of their organization meaningful had engagement levels of 18% above average. This means that employees aligned with the vision of their companies aren’t just working for a paycheck; they’re working because they believe in the company and find meaning in their work. This can help improve employee retention and even your overall bottom line.

Is a vision statement the same as a mission statement?

03. Don't be too specific with your statement

A vision statement should address broad and ambitious future goals. There's no need to elaborate on these in detail. Your statement should outline an overview of what you plan to achieve and provide inspiration. This is typically not the place to write specific objectives, such as, "We want to hit $5,000,000 in sales by 2025." You can, however, include these details in your expanded vision statement document, if you choose to create one.

04. Come up with a list of values

Next, come up with a list of values that your business adheres to and incorporate the most important one(s) into your statement. By referencing your company's core values, your vision statement will better encompass what your company stands for. This will also help make your vision statement a part of your company culture.

Continuing with the example of the insurance company, let's say it wants to highlight the fact that it is:

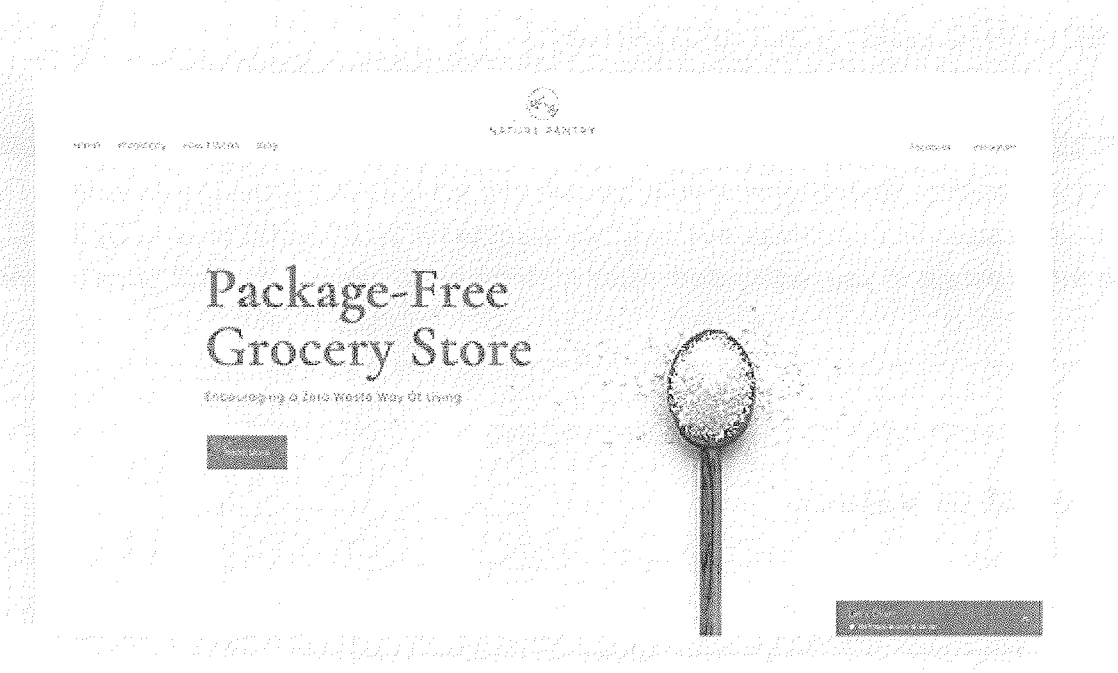
- Reliable
- Dependable
- Understanding
- Sympathetic
- Comforting

In this case, the vision statement could read:

"Our vision is to not only provide insurance, but to be a friend to our customers. We will provide a sense of long-term ***comfort*** *and security in their lives by providing 24/7 customer support."*

05. Make your statement actionable

The point of a vision statement is to identify a long-term goal for your business to work towards. Make sure to include actionable terminology to show that your business is moving forward and continuously striving. Examples might include:



02. Determine long-term goals

Consider what goals you hope to achieve 5-10 years down the line that can set you apart from the competition. Why should someone buy from you instead of the person down the street?

Consider our example of the insurance company. There are hundreds, if not thousands of insurance companies in the US, each one needing to set itself apart from the competition. Perhaps an insurance company wants to offer significantly lower rates or provide better customer service than their competitors. Or perhaps, it has a unique business model, like Lemonade, that donates leftover funds to charities of their customers' choice. These are the kinds of aspects that you could highlight in your vision statement.

With that in mind, let's take the statement above and expand on it:

"Our vision is to not only provide insurance, but to be a friend to our customers. We will provide a sense of long-term security in their lives by providing 24/7 customer support."

Ex. 8

ROCHESTER AREA
CHAMBER OF COMMERCE
LEADERSHIP GREATER ROCHESTER

Crafting Your Personal Mission Statement

Class of 2006 Retreat
September 8-9, 2005
Good Earth Village, Spring Valley, Minnesota

Presented by Michon D. Rogers
Rochester Public Schools

again, ADT & Shelters & families & Doctors say these is waste & they especially for this black male.

Determining and Living Your Life According to Your Core Values

Directions: Place an "X" by 20 values that are key to you. Narrow the list to ten core values and then further narrow the list to three core values. Use these three core values as a common thread to weave throughout the writing of your mission statement.

___ Achievement
___ Advancement and Promotion
___ Adventure
___ Affection (love and caring)
___ Arts
___ Challenging problems
___ Change and variety
___ Close relationships
___ Community
___ Competence
___ Competition
___ Cooperation
___ Country
___ Creativity
___ Decisiveness
___ Democracy
___ Ecological awareness
___ Economic security
___ Effectiveness
___ Efficiency
___ Ethical practice
___ Excellence
___ Expertise
___ Fame
___ Fast living
___ Fast-paced work
___ Financial gain
___ Freedom
___ Friendships
___ Growth
___ Having a family
___ Helping other people
___ Helping society
___ Honesty
___ Independence
___ Influencing others
___ Inner harmony
___ Inner passion
___ Integrity
___ Intellectual status
___ Involvement
___ Job tranquility
___ Knowledge
___ Leadership
___ Location
___ Loyalty
___ Market position
___ Meaningful work
___ Merit
___ Money
___ Nature
___ Being around people who are open and honest
___ Order (tranquility, stability)
___ Personal development (living up to my full potential)
___ Physical challenge
___ Pleasure
___ Power and authority
___ Privacy
___ Public service
___ Purity
___ Quality of what I take part in
___ Quality relationships
___ Recognition (respect from others)
___ Religion
___ Reputation
___ Responsibility and accountability
___ Security
___ Self-respect
___ Serenity
___ Sophistication
___ Stability
___ Status
___ Supervising others
___ Time freedom
___ Truth
___ Wealth
___ Wisdom
___ Work under pressure
___ Work with others
___ Working alone
___ _____
___ _____
___ _____

Source: Adapted from *The Fifth Discipline Fieldbook* by P.M. Senge, Currency Publisher, 1994.

Mission Statement Draft

Preparation

Completing the following statements may help you determine the focus and wording of your personal mission statement.

I am at my best when . . .

I am at my worst when . . .

I am truly happy when . . .

I want to be a person who . . .

Someday I would like to . . .

My deepest positive emotions come when . . .

My greatest talents and best gifts are . . .

When all is said and done, the most important things in life are . . .

Possible life goals for me are . . .

Review

Writing a mission statement requires deep reflection about who we are and what our purpose is. Review your mission statement when it is still in draft form. Ask yourself the following questions.

Does my mission statement …

Bring out the best in me?

Challenge and motivate me?

Communicate my vision and values?

Address significant roles in my life?

Express timelines, proven principles that produce quality of life results?

Represent the unique contribution I can make to society?

The Creation of a Personal Mission Statement

By following the suggested six steps below, you will be able to begin writing a personal mission statement that will inspire you and will provide direction and guidance for your life. Remember that a personal mission statement is as much discovery as it is creation. Don't rush it or set rigid timetables for yourself; rather, go slowly through the process, ask yourself the right questions, and think deeply about your values and aspirations.

A meaningful personal mission statement contains two basic elements. The first is what you want to do – what you want to accomplish, what contributions you want to make. The second is what you want to be – what character strengths you want to have, what qualities you want to develop.

Step 1 Define what you want to be and do

Some of the elements I would like to have in my mission statement are:

What I'd like to do:	What I'd like to be:

Step 2 Identify an Influential Person

An effective tool to focus in on what you want to be and do is to identify a highly influential individual in your life and to think about how this individual has contributed to your life. This person may be a parent, work associate, friend, family member, or neighbor. Answer the following questions, keeping in mind your personal goals on what you want to be and do.

Who has been one of the most influential people in my life?

Which qualities do I most admire in that person?

What qualities have I gained (or desire to gain) from that person?

Step 3 Define your Life Roles

You live your life in terms of roles – not in the sense of role playing, but in the sense of authentic parts you have chosen to fill. You may have roles in work, in the family, in the community, and in other areas of your life. These roles become a natural framework to give order to what you want to do and to be.

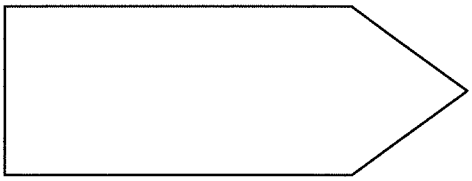
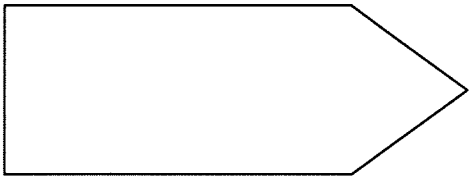
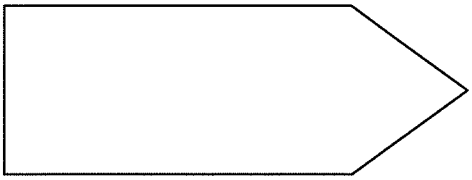
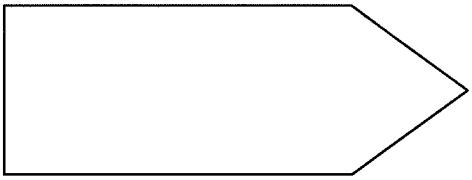
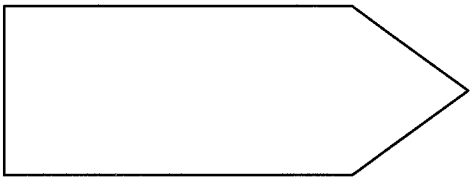
You may define your family role as simply "family member." Or, you may choose to divide it into roles, such as "wife" and "mother" or "husband" and "father." Some areas of your life, such as your profession, may involve several roles. For example, you may have one role in administration, one in marketing, one in personnel, and one in long-range planning. Examples:

> *Wife/Mother, Manager-New Products, Manager-Research, Manager-Staff Development, United Way Chairperson, Friend*
>
> *Husband/Father, Salesman-Prospects, Salesman – Financing/Administration, March of Dimes Regional Director, Friend*

Define up to six life roles and then write these roles in the boxes provided on the next page. Then project yourself forward in time and write a brief statement of how you would most like to be described in that particular role.

By identifying your life roles you will gain perspective and balance. By writing these descriptive statements you will begin to visualize your highest self. You will also identify the core principles and values you desire to live by.

Step 3 Define your Life Roles (continued)

Roles	Statement
	
	
	
	
	
	

Step 4 Write a Draft of your Personal Mission Statement

Now that you have identified your life roles and have defined what you want to be and do, you are prepared to begin working on your personal mission statement.

In the space provided below create a rough draft of your mission statement. Draw heavily upon the thinking you've done in the previous three steps. Carry this draft with you and make notes, additions, and deletions before you attempt another draft.

Step 5 Evaluate

It is important that you do not let your personal mission statement become outdated. Periodic review and evaluation can help you keep in touch with your own development and keep your statement in harmony with your deepest self. Continually ask yourself the following questions.

Is my mission based on timeless, proven principles? Which ones?

_____

_____

Do I feel this represents the best that is within me?

_____

_____

During my best moments, do I feel good about what this represents?

_____

_____

Do I feel direction, purpose, challenge, and motivation when I review this statement?

_____

_____

Am I aware of the strategies and skills that will help me accomplish what I have written?

_____

_____

What do I need to start doing now to be where I want to be tomorrow?

_____

_____

The final test ... does this statement inspire me?

_____

_____

Step 6 Write a Permanent Draft

We recommend that you keep a rough draft of your mission statement for a period of time while to revise and evaluate. Be sure it inspires the best within you.

When you do have a permanent copy, review it frequently. We strongly recommend that you commit it to memory so that you keep your vision and your values clearly in mind.

Personal Growth

How to Write a Personal Mission Statement

5 MIN READ | SEP 23, 2021

By **Ramsey Solutions**

You probably have seen mission statements everywhere.

They're on walls in company lobbies and inside promotional brochures. Mission statements define a business or organization's identity and purpose, and can go a long way in helping the company cast vision for its future.

But did you know they aren't just for big companies? You can have a mission statement too! This is called a **personal mission statement**, and it could be what you've needed to identify your goals and find the motivation to accomplish them.

What Is a Personal Mission Statement?

A personal mission statement defines who you are as a person (or as a team member where you work) and identifies your purpose, whether that's in the office or simply in life. It explains how you aim to pursue that purpose, and why it matters so much to you.

Author and career coach Dan Miller says **a good mission statement should include three things:**

1. Your skills and abilities (what you like to do)
2. Your personality traits (how you operate)
3. Your values, dreams and passions (why you want to excel)

That's it! It should be just one or two sentences long and say—in simple terms—exactly what you're all about without any principles tacked on.

Why a Personal Mission Statement Is Useful

Whether you're a stay-at-home parent, store manager, college student, business executive, or truck driver, crafting a personal mission statement will serve you well in life. Everyone should have one!

It's important because it helps you focus on how to meet your long-term goals. It serves as a guidepost for where you want to go in life. The cost of writing a mission statement is small, but the payoff is huge because—simply put—it works!

That's because a personal mission statement keeps you from wandering off track. For example, if a decision you plan to make doesn't fit within the confines of your personal mission statement, you shouldn't follow through with it. Something may be a cool idea, but that doesn't mean you need to bring it into your life.

Dave Ramsey says a good mission statement becomes an out-of-bounds marker for your ideas. If your passion is being outdoors, is it really wise to hole yourself up in an office your entire career? Be realistic, and don't set yourself up for failure.

People fail at what they hope to achieve because they lack clear goals and focus. They run down too many rabbit trails and lose sight of who they were made to be. In other words, they ignore their personal mission statement. **But a successful person will have a rock-solid vision spelled out in their personal mission statement.**

If you don't already have a personal mission statement, there's no time like the present to write one.

How to Write a Personal Mission Statement

Once they're written, personal mission statements seem simple. But if they're done well, they require a lot of effort to create. So take some time to think about and write down how each of Miller's three areas apply to you. That lays a good foundation for crafting your mission statement.

Think about your life principles and goals. Why did you set these goals? How do your goals make you a better person? The mission statement should answer these questions in 50 words or less, so try to get to the heart of who you are and exclude unnecessary details. Don't worry if your statement doesn't mirror someone else's—every statement is different because no two people are the same.

Putting Your Personal Mission Statement to Use

Once you have a written mission statement, start using it! Frame it and put a copy in your home or office so you see it often. You want to surround yourself with your own positive attitude.

Not only should you live according to your personal mission statement, but it's also important others know about it as well. You want people to know you're going to live up to what you wrote, so spread the news! Accountability from those closest to you will help you stick to it.

Examples of Personal Mission Statements

Speaking of letting people know, the Ramsey Solutions mission statement is posted throughout the building, and every team member is required to know it like the back of their hand. It's why we exist. It goes like this:

"We provide biblically based, commonsense education and empowerment that give HOPE to everyone in every walk of life."

But that's a business mission statement. Here are a few examples of personal mission statements from successful CEOs in business:

"To be a teacher. And to be known for inspiring my students to be more than they thought they could be." — Oprah Winfrey

"To have fun in [my] journey through life and learn from [my] mistakes." — Sir Richard Branson, founder of the Virgin Group

"To use my gifts of intelligence, charisma, and serial optimism to cultivate the self-worth and net-worth of women around the world." — Amanda Steinberg, founder of DailyWorth

And here are a few other mission statements from some well-known nonprofits:

"To inspire hope, and contribute to health and well-being by providing the best care to every patient through integrated clinical practice, education and research." — Mayo Clinic

"Seeking to put God's love into action, Habitat for Humanity brings people together to build homes, communities and hope." — Habitat for Humanity

"To create content that educates, informs and inspires." — Public Broadcasting System (PBS)

Ready to start working on your own personal mission statement? **Having your purpose written down will add value and productivity to your life, so get started today!**

*Want to better understand your personal strengths so you can craft a better mission statement? **Get the DISC Personality Test!** It's all done online, so order and take your test today!*

ABOUT THE AUTHOR

Ramsey Solutions

Ramsey Solutions has been committed to helping people regain control of their money, build wealth, grow their leadership skills, and enhance their lives through personal development since 1992. Millions of people have used our financial advice through 22 books (including 12 national bestsellers) published by Ramsey Press, as well as two syndicated radio shows and 10 podcasts, which have over 17 million weekly listeners. Learn More.

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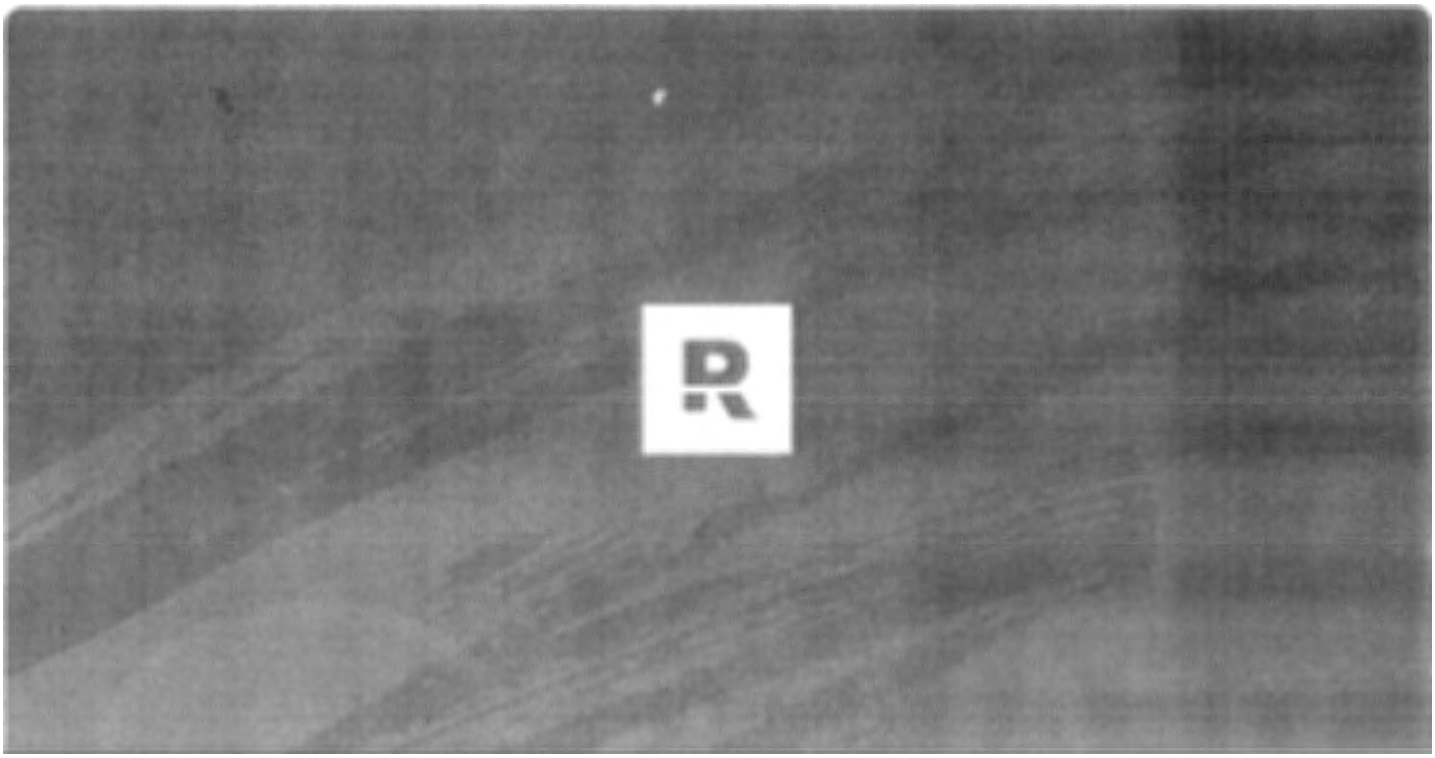

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Personal Mission Statement Samples

My mission is to give, for giving is what I do best and I can learn to do better.

I will seek to learn, for learning is the basis for growth and growing is the key to living.

I will seek first to understand, for understanding is the key to finding value and value is the basis for respect, decisions and action. This should be my first act with my wife, my family, and my business.

I want to help influence the future development of people and organizations. I want to teach my children and others to love and laugh, to learn and grow beyond their current bounds.

I will build personal, business and civic relationships by giving frequently in little ways.

I see each day as a clean slate, a fresh chance to write a new script and seize new opportunities. I value life's experiences and seek to learn and grow from each one. In my daily endeavors, I avoid neither risk nor responsibility; nor do I fear failure, only lost opportunity.

I am a responsible spouse and parent; I give priority to these roles. I value differences and view them as strengths. I seek to build complementary win-win relationships with family, friends, and business associates. To keep these relationships healthy and to maintain a high level of trust, I make daily "deposits" in the "emotional bank accounts" of others.

In my profession, I am responsible for results. I act with courage, consideration, and discretion. I prefer to let my works speak for me and believe in achieving visibility through productivity. In planning my weeks and days, I focus on key roles and goals to maintain balance and perspective. Knowing that how I perform affects how I feel about myself, I seek to do my best and record how I feel in daily entries in a personal journal.

I value my personal freedom of choice and my rights to exercise that freedom. I am more a product of my decisions than conditions. I do not allow present circumstances or past conditioning to determine my responses to the challenges I face. I choose to focus on the positive, to work within my circle of influence – to act directly on things I can do something about – and thereby reduce my circle of concern.

Source: *The 7 Habits of Highly Effective People* by Stephen R. Covey, Free Press, 2004.

How to write a vision statement

Most companies, especially large corporations, have a vision statement consisting of one or two sentences as well as a multipage document describing its future plans. As the business owner, it's really up to you to decide if you want to extend your vision statement beyond a few sentences or not. But no matter how long or short you make it, what's important is that you have one.
Without a vision statement, your business has the potential to veer off course. You and your employees can lose sight of what you are working for and what you are trying to achieve.

While there are no hard and fast rules for writing vision statements, these five steps can help you with the process:

1. Define the purpose of your business
2. Determine long-term goals
3. Don't be too specific with your statement
4. Come up with a list of values
5. Make your statement actionable

01. Define the purpose of your business

By purpose, we don't simply mean the product you make. Think about the bigger picture: what does your business bring to the world that no other business does? Consider how you intend your product or service to change people's lives for the better. How will the future be different with your business thriving in it?

For example, an insurance company doesn't just provide insurance. It also provides customers with financial security and peace of mind knowing that they are taken care of if things go wrong. Using that idea, an insurance company could create a vision statement such as,

"Our vision is to not only provide insurance, but to be a friend to our customers by providing a sense of long-term security in their lives."

Mar 3, 2021 6 min read

How to Write the Perfect Vision Statement, Plus Examples

EX. 9

Modern society has shown us the value of living in the present. Meditation and mindfulness practices have become so common that they're touted by celebrities such as Jerry Seinfeld and Goldie Hawn. And we are all for it. But when it comes to business, it's a whole other ball game.

Living in the moment certainly has its advantages, but business is about planning for the future. From creating your business website to building your product, you need to strategically project costs, revenue, and your vision for the future.

That's where vision statements come in. Not to be confused with a mission statement, an effective vision statement clearly outlines the aspirations of your business and what you hope to achieve long-term. You'll need to consider questions such as, *What is your company's overall vision for the future?* and *How are you going to help consumers long-term?*

After you've answered these questions, you can follow our five steps for writing the perfect vision statement.

Drugs.com
Know more. Be sure.

Seroquel Side Effects

Generic name: *quetiapine*

Medically reviewed by Drugs.com. Last updated on Oct 11, 2022.

Note: This document contains side effect information about quetiapine. Some dosage forms listed on this page may not apply to the brand name Seroquel.

Summary

Common side effects of Seroquel include: asthenia, constipation, dizziness, drowsiness, headache, increased serum cholesterol, increased serum triglycerides, increased thyroid stimulating hormone level, and xerostomia. **Other side effects** include: abdominal pain, dyspepsia, increased serum alanine aminotransferase, orthostatic hypotension, pharyngitis, weight gain, and tachycardia. Continue reading for a comprehensive list of adverse effects.

Applies to quetiapine: **oral tablet, oral tablet extended release**.

Warning

Oral route (Tablet; Tablet, Extended Release)

Increased Mortality in Elderly Patients with Dementia-Related PsychosisElderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Quetiapine fumarate is not approved for the treatment of patients with dementia-related psychosis.Suicidal Thoughts and BehaviorsIncreased risk of suicidal thoughts and behavior in children, adolescents and young adults taking antidepressants.Monitor for worsening and emergence of suicidal thoughts and behaviors.

Serious side effects of Seroquel

Along with its needed effects, quetiapine (the active ingredient contained in Seroquel) may cause some unwanted effects. Although not all of these side effects may occur, if they do occur they may need medical attention.

Check with your doctor immediately if any of the following side effects occur while taking quetiapine:

More common

- Chills
- cold sweats
- confusion
- dizziness, faintness, or lightheadedness when getting up suddenly from a lying or sitting position
- sleepiness or unusual drowsiness

Less common

- Black, tarry stools
- blurred vision
- changes in patterns and rhythms of speech
- chest pain
- cough
- drooling
- fever
- inability to move the eyes
- inability to sit still
- increased blinking or spasms of the eyelid
- lip smacking or puckering
- loss of balance control
- mask-like face
- muscle aches
- need to keep moving
- painful or difficult urination
- puffing of the cheeks
- rapid or worm-like movements of the tongue
- restlessness
- shakiness in the legs, arms, hands, or feet

IR Formulations:

Uncommon (0.1% to 1%): Creatinine increased

Rare (0.01% to 0.1%): Acute kidney failure, glycosuria[Ref]

Frequently asked questions

- How does Vraylar compare with Seroquel?

References

1. "Product Information. Seroquel (quetiapine)." Astra-Zeneca Pharmaceuticals (2001):

2. Cerner Multum, Inc. "UK Summary of Product Characteristics." O 0

3. "Product Information. Seroquel XR (quetiapine)." Astra-Zeneca Pharmaceuticals (2007):

4. Cerner Multum, Inc. "Australian Product Information." O 0

Further information

Always consult your healthcare provider to ensure the information displayed on this page applies to your personal circumstances.

Some side effects may not be reported. You may report them to the FDA.

- cloudy urine
- decrease in height
- decreased urine output
- difficulty swallowing
- feeling that others are watching you or controlling your behavior
- feeling that others can hear your thoughts
- feeling, seeing, or hearing things that are not there
- hives, itching, skin rash
- increased sensitivity of the skin to sunlight
- increased thirst
- irritability
- joint or muscle pain
- loss of balance control
- loss of consciousness
- mask-like face
- pain in the back, ribs, arms, or legs
- pain or swelling in the arms or legs without any injury
- puffiness or swelling of the eyelids or around the eyes, face, lips, or tongue
- red skin lesions, often with a purple center
- red, irritated eyes
- redness or other discoloration of the skin
- seizures
- severe mood or mental changes
- severe sunburn
- shuffling walk
- slow heartbeat

- slowed movements
- slurred speech
- sores, ulcers, or white spots in the mouth or on the lips
- stiffness of the arms and legs
- swelling of the face, ankles, or hands
- swollen or painful glands
- tic-like (jerky) movements of the head, face, mouth, and neck
- unusual behavior

Get emergency help immediately if any of the following symptoms of overdose occur while taking divalproex sodium:

Symptoms of overdose

- Change in consciousness
- fainting
- loss of consciousness
- slow or irregular heartbeat

Other side effects of Depakote

Some side effects of divalproex sodium may occur that usually **do not need medical attention.** These side effects may go away during treatment as your body adjusts to the medicine. Also, your health care professional may be able to tell you about ways to prevent or reduce some of these side effects.

Check with your health care professional if any of the following side effects **continue or are bothersome** or if you have any questions about them:

More common

- Belching
- body aches or pain
- change in vision
- congestion

- degenerative disease of the joint
- difficulty with moving
- dizziness
- dizziness, faintness, or lightheadedness when getting up suddenly from a lying or sitting position
- dry mouth
- excessive muscle tone
- fast, irregular, pounding, or racing heartbeat or pulse
- feeling of warmth or heat
- flushing or redness of the skin, especially on the face and neck
- frequent urge to urinate
- heavy non-menstrual vaginal bleeding
- increased need to urinate
- indigestion
- lack of coordination
- large, flat, blue or purplish patches in the skin
- leg cramps
- lip smacking or puckering
- loss of bladder control
- loss of strength or energy
- multiple swollen and inflamed skin lesions
- muscle pain or stiffness
- muscle tension or tightness
- normal menstrual bleeding occurring earlier, possibly lasting longer than expected
- numbness of the feet, hands and around mouth
- pains in the stomach, side, or abdomen, possibly radiating to the back
- passing urine more often

- pounding in the ears
- puffing of the cheeks
- rapid or worm-like movements of the tongue
- rapid weight gain
- restlessness
- seeing, hearing, or feeling things that are not there
- shakiness and unsteady walk
- slurred speech
- small red or purple spots on the skin
- sweating
- swollen joints
- trouble with speaking
- twitching
- uncontrolled chewing movements
- uncontrolled movements of the arms and legs
- unsteadiness, trembling, or other problems with muscle control or coordination
- vomiting of blood or material that looks like coffee grounds
- yellow eyes or skin

Incidence not known

- Aggression
- bladder pain
- blistering, peeling, loosening of the skin
- blisters on the skin
- bone pain, tenderness, or aching
- chest discomfort

occurred shortly after initiation as well as several years after use. If pancreatitis is diagnosed, valproate should ordinarily be discontinued.

Serious side effects of Depakote

Along with its needed effects, divalproex sodium (the active ingredient contained in Depakote) may cause some unwanted effects. Although not all of these side effects may occur, if they do occur they may need medical attention.

Check with your doctor immediately if any of the following side effects occur while taking divalproex sodium:

More common

- Black, tarry stools
- bleeding gums
- bloating or swelling of the face, arms, hands, lower legs, or feet
- blood in the urine or stools
- chills
- confusion
- cough
- crying
- delusions of persecution, mistrust, suspiciousness, or combativeness
- diarrhea
- difficult or labored breathing
- dysphoria
- false beliefs that cannot be changed by facts
- false or unusual sense of well-being
- feeling of unreality
- fever
- general feeling of discomfort or illness

Depakote Side Effects

EX. 1

Generic name: *divalproex sodium*

Medically reviewed by Drugs.com. Last updated on Apr 15, 2022.

Note: This document contains side effect information about divalproex sodium. Some dosage forms listed on this page may not apply to the brand name Depakote.

Summary

Common side effects of Depakote include: abdominal pain, asthenia, dizziness, drowsiness, nausea, and anorexia. **Other side effects** include: abnormality in thinking, alopecia, ataxia, nystagmus disorder, tremor, weight loss, fever, and skin rash. Continue reading for a comprehensive list of adverse effects.

Applies to divalproex sodium: **oral capsule delayed release, oral tablet delayed release, oral tablet extended release**.

Warning

Oral route (Tablet, Delayed Release; Capsule, Delayed Release; Tablet, Extended Release)

Hepatotoxicity (some cases fatal), usually occurring during the first 6 months of treatment, has been reported in patients receiving valproate and its derivatives. Children younger than 2 years and patients with hereditary mitochondrial disease are at a considerably increased risk of developing fatal hepatotoxicity. For these patients under 2 years, valproate sodium should be used with extreme caution as a sole agent. Use is contraindicated in patients with known mitochondrial disorders caused by mitochondrial DNA polymerase gamma (POLG) mutations and in children younger than 2 years in which mitochondrial disorder is clinically suspected. Failure of other anticonvulsants is the only indication for divalproex sodium in patients older than 2 years with hereditary mitochondrial disease. Perform POLG mutation screening as clinically indicated. Monitor patients closely and perform liver function tests prior to therapy and at frequent intervals thereafter, especially during the first 6 months. Valproate can impair cognitive development with prenatal exposure and produce major congenital malformations, particularly neural tube defects (eg, spina bifida). Valproate is contraindicated for prophylaxis of migraine headaches in pregnant women and women of childbearing potential who are not using effective contraception. Valproate should not be administered to a woman of childbearing potential unless other medications have failed or are otherwise unacceptable. Effective contraception should be used in such situations. Life-threatening pancreatitis has been reported in both children and adults receiving valproate. Cases have

Table 5

The Composite International Diagnostic Interview (CIDI)[a]

I. Stem Questions
1. Some people have periods lasting several days or longer when they feel much more excited and full of energy than usual. Their minds go too fast. They talk a lot. They are very restless or unable to sit still, and they sometimes do things that are unusual for them, such as driving too fast or spending too much money. Have you ever had a period like this lasting several days or longer?[b]
2. Have you ever had a period lasting several days or longer when most of the time you were so irritable or grouchy that you started arguments, shouted at people, or hit people?
II. Criterion B Screening Questions
1. People who have episodes like this often have changes in their thinking and behavior at the same time, like being more talkative, needing very little sleep, being very restless, going on buying sprees, and behaving in ways they would normally think are inappropriate. Did you ever have any of these changes during your episodes of being excited and full of energy/very irritable or grouchy?
III. Criterion B Symptom Questions
Think of an episode when you had the largest number of changes like these at the same time. During that episode, which of the following changes did you experience?
1. Were you so irritable that you either started arguments, shouted at people, or hit people?[c]
2. Did you become so restless or fidgety that you paced up and down or couldn't stand still?
3. Did you do anything else that wasn't usual for you—like talking about things you would normally keep private or acting in ways that you would usually find embarrassing?
4. Did you try to do things that were impossible to do, like taking on large amounts of work?
5. Did you constantly keep changing your plans or activities?
6. Did you find it hard to keep your mind on what you were doing?
7. Did your thoughts seem to jump from one thing to another or race through your head so fast you couldn't keep track of them?
8. Did you sleep far less than usual and still not get tired or sleepy?
9. Did you spend so much more money than usual that it caused you to have financial trouble?

[a]Reprinted with permission from Kessler and Akiskal.[23]

[b]If this question is endorsed, the irritability stem question is skipped and the respondent goes directly to the criterion B screening question.

[c]This question is asked only if the euphoria stem question is endorsed.

Table 6

DSM-5 Bipolar Disorder Subtypes[a]

Subtype	*DSM-5* Definition
Bipolar I disorder	≥ 1 manic episode with/without psychotic features; the manic episode may have been preceded by hypomanic or major depressive episodes
Bipolar II disorder	≥ 1 major depressive episode accompanied by at least 1 hypomanic episode; no prior manic episode
Cyclothymic disorder	Numerous periods of hypomanic and depressive symptoms for at least 2 years (adults); do not meet criteria for a hypomanic or major depressive episode
Other specified bipolar and related disorders	History of MDD and criteria for hypomania (except duration is < 4 consecutive days)
	History of MDD and hypomanic episodes with insufficient symptoms to meet criteria for bipolar II disorder (although duration is ≥ 4 days)
	Hypomanic episode without MDD
	Short-duration cyclothymia
Specifiers for bipolar disorders	
Rapid cycling	≥ 4 episodes of manic, hypomanic, or major depressive episodes during a 12-month period
Anxious distress	At least 2 of the following symptoms on most days during most recent mood episode:
	Feeling keyed up or tense
	Feeling unusually restless
	Difficulty concentrating because of worry
	Fear that something awful may happen
	Feeling that individual might lose control
Mixed features	Manic or hypomanic episode, with mixed features
	Full criteria for a manic or hypomanic episode, with at least 3 of the following depressive symptoms:
	Prominent dysphoria or depressed mood
	Diminished interest or pleasure in activities
	Psychomotor retardation
	Fatigue or loss of energy
	Feelings of worthlessness or excessive or inappropriate guilt

[a]Based on American Psychiatric Association.[5]

Abbreviation: MDD = major depressive disorder.

Table 7

Differential Diagnoses for Bipolar Disorder

Anxiety Disorders (including panic disorder, agoraphobia [fear of public places], social phobias, separation anxiety disorder, and generalized anxiety disorder)

Anxiety disorders commonly mimic, as well as co-occur with, bipolar disorder.[33] In particular, the physician may have to decide whether symptoms such as psychomotor acceleration, tension, or agitation are more appropriately explained by an anxiety disorder or hypomania (or both).[31] Cluster B personality disorders can also exhibit features, such as mood instability and impulsivity, that are common to mania or hypomania.[31] The chronic stress experienced by patients with anxiety disorders can induce depressive symptoms (for example, irritability, hopelessness, despair, emptiness, and chronic fatigue)[30]

Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is characterized by overactivity, impulsive behavior, and poor judgment that can overlap with the symptoms of bipolar disorder. ADHD and bipolar disorder are also commonly present together. The co-occurrence of ADHD modifies the course of bipolar illness.[34] In the diagnosis of ADHD, the condition is formally recognized as a neurodevelopmental disorder

Major Depressive Disorder (MDD)

The symptoms of bipolar depression and MDD can be indistinguishable. Family history, treatment response, the frequency of recurrences, and (particularly) the presence of manic or hypomanic symptoms can all assist the physician to distinguish bipolar disorder from MDD[14–16]

Personality Disorders

Individuals diagnosed with personality disorders are particularly vulnerable to depression and substance use disorders.[30] Patients with substance abuse may have all 3 diagnoses. Personality disorders are classified in the *DSM-5* as Axis II disorders; therefore, depression may frequently be diagnosed separately (from the personality disorder) as an adjustment disorder, dysthymia, or MDD[30]

Posttraumatic Stress Disorder

Characteristic *DSM-5* symptoms, categorized into 4 clusters (vs 3 clusters in the *DSM-IV*), include episodes in which the traumatic event or emotions linked to the event are reexperienced; nightmares, exaggerated startle responses; and withdrawal on a social, interpersonal, and psychological level. Anxiety and depression may feature as chronic symptoms. Posttraumatic stress disorder is classified as a trauma- and stressor-related disorder[30]

Schizoaffective Disorder and Schizophrenia

Chronic depression representative of MDD is observed in patients with schizoaffective

Table 8

Clinical Decision Steps in Bipolar Management

1. Determine whether there is a need for immediate specialist psychiatric intervention
2. Consider the resources and the multidisciplinary team required for successful management in primary care
3. Set treatment goals and select evidence-based treatment(s) for acute and long-term treatment, involving the patient in decision-making whenever possible
4. Gain familiarity with the monitoring recommendations for continued patient care, including ongoing evaluations of bipolar symptoms and functioning, treatment-related adverse effects, adherence, and general health status

Table 9

US Food and Drug Administration–Approved Oral Medications in the Treatment of Adults With Bipolar Disorder[a]

Medication	Mania	Depression	Mixed	Maintenance
Lithium	✓	—	—	✓
Carbamazepine, carbamazepine extended release	✓	—	✓	—
Lamotrigine	—	—	—	✓
Divalproex, divalproex extended release	✓	—	—	—
Aripiprazole	✓ (monotherapy and adjunctive therapy)	—	✓ (monotherapy and adjunctive therapy)	✓ (monotherapy and adjunctive therapy)
Asenapine	✓ (monotherapy and adjunctive therapy)	—	✓ (monotherapy and adjunctive therapy)	—
Lurasidone	—	✓ (monotherapy and adjunctive therapy)	—	—
Olanzapine	✓ (monotherapy and adjunctive therapy)	✓ (combined with fluoxetine)	✓ (monotherapy and adjunctive therapy)	✓ (monotherapy)
Quetiapine immediate release, extended release	✓ (monotherapy and adjunctive therapy)	✓ (monotherapy)	✓ (extended release only: monotherapy and adjunctive therapy)	✓ (adjunctive therapy)
Risperidone	✓ (monotherapy and adjunctive therapy)	—	✓(monotherapy and adjunctive therapy)	✓ (risperidone long-acting injection only: monotherapy and adjunctive therapy)
Ziprasidone	✓ monotherapy)	—	✓ (monotherapy)	✓ (adjunctive therapy)

[a]Based on Bobo and Shelton[60] and Loganathan et al.[61]

Symbols: ✓ = approved, — = not approved.

Table 10

Characteristic Adverse Effects of Pharmacologic Treatments for Bipolar Disorder[a]

Treatment	Notable Adverse Effects
Lithium	Thirst, polyuria, diabetes insipidus
	Sedation
	Tremor
	Weight gain
	Diarrhea, nausea
	Cognitive effects
Carbamazepine	Headache
	Fatigue
	Nystagmus
	Ataxia
	Rash (including Stevens-Johnson syndrome and toxic epidermal necrolysis)
	Leukopenia, hyponatremia
Divalproex, divalproex extended release	Tremor
	Sedation
	Weight gain
	Nausea
	Diarrhea
	Hair loss
	Leukopenia, thrombocytopenia
	Elevated liver transaminase levels, hepatic failure, pancreatitis
	Polycystic ovary syndrome
Lamotrigine	Dizziness, tremor
	Somnolence, headache
	Dry mouth, nausea
	Rash (including Stevens-Johnson syndrome and toxic epidermal necrolysis)
	Leukopenia, thrombocytopenia, pancytopenia
	Aseptic meningitis
Atypical antipsychotics	
Aripiprazole	Akathisia, other EPS, sedation, hyperglycemia
Asenapine	EPS, sedation, dyslipidemia, hyperglycemia

[a]Based on Price and Marzani-Nissen[2] and Chung et al.[51]

Abbreviation: EPS = extrapyramidal symptoms.

Table 11

Recommended Monitoring for Pharmacologic Treatments[a]

Treatment	Recommended Monitoring
Lithium	Serum drug levels every 3 to 6 mo once stable levels have been reached
	Electrolytes, urea, creatinine every 3 to 6 mo (to exclude renal impairment)
	Thyroid-stimulating hormone, calcium, and weight after 6 mo and annually thereafter (to exclude thyroid or parathyroid abnormalities)
Carbamazepine	Serum drug levels during treatment initiation and then as clinically indicated
	Conduct complete blood count, liver function tests, and electrolytes, urea, and creatinine assessments monthly for 3 mo and annually to exclude blood dyscrasias, liver failure, hyponatremia
	Monitor for rash (to exclude Stevens-Johnson syndrome)
Divalproex	Serum drug levels during treatment initiation and then as clinically indicated
	Conduct weight, complete blood count, menstrual history, and liver function tests every 3 mo (first year) and annually to exclude thrombocytopenia, dysmenorrhea, liver failure
Lamotrigine	Monitor for rash (to exclude Stevens-Johnson syndrome)
Atypical antipsychotics	Assess weight monthly for 3 mo and every 3 mo thereafter
	Blood pressure, blood glucose and serum lipids every 3 mo and annually thereafter to exclude metabolic syndrome
	Monitor for abnormal movements (to exclude extrapyramidal symptoms)
	Conduct electrocardiogram or prolactin evaluation as clinically indicated

[a]Based on Connolly and Thase.[55]

Table 12

Early Signs of Relapse (in order of decreasing frequency)[a]

Mania	Depression
Sleep disturbance	Low mood
Psychotic symptoms	Psychomotor symptoms
Mood change	Appetite changes
Psychomotor symptoms	Increased anxiety
Appetite change	Suicidal ideas/intent
Increased anxiety	Sleep disturbance

[a]Based on Jackson et al.[98]

- joint or muscle pain
- light-colored stools
- loss of consciousness
- lower back or side pain
- muscle cramps, spasms, stiffness, or twitching
- nausea
- painful or prolonged erection of the penis
- painful urination
- pains in the stomach, side, or abdomen, possibly radiating to the back
- puffiness or swelling of the eyelids or around the eyes, face, lips, or tongue
- red skin lesions, often with a purple center
- red, irritated eyes
- seizures
- severe constipation
- severe sleepiness
- severe vomiting
- sore throat
- stomach pain, continuing
- tightness in the chest
- tingling of the hands or feet
- unusual bleeding or bruising unusual drowsiness, dullness, or feeling of sluggishness
- unusual weight gain or loss
- upper right abdominal pain
- vomiting
- yellow eyes or skin

Other side effects of Seroquel

Some side effects of quetiapine may occur that usually **do not need medical attention**. These side effects may go away during treatment as your body adjusts to the medicine. Also, your health care professional may be able to tell you about ways to prevent or reduce some of these side effects.

Check with your health care professional if any of the following side effects **continue or are bothersome** or if you have any questions about them:

Less common

- Abnormal vision
- belching
- decreased appetite
- decreased strength and energy
- heartburn
- increased appetite
- increased muscle tone
- increased sweating
- indigestion
- sneezing
- stomach discomfort or upset
- stuffy or runny nose

For Healthcare Professionals

Applies to quetiapine: **oral tablet, oral tablet extended release**.

General

IR Formulations: The most commonly reported side effects included somnolence, dry mouth, weight gain, elevated triglycerides, headache, and agitation.

XR/XL Tablets: The most commonly reported side effects included somnolence, dry mouth, and sedation.[Ref]

Nervous system

IR Formulations:

Very common (10% or more): Somnolence (up to 57%), headache (up to 21%), dizziness (up to 19%), sedation (up to 18.3%), extrapyramidal symptoms (up to 12.9%)

Common (1% to 10%): Akathisia, ataxia, balance disorder, dysarthria, dyskinesia, dyskinetic event, dystonic event, extrapyramidal disorder, hypersomnia, hypertonia, hypoesthesia, incoordination, lethargy, other extrapyramidal event, paresthesia, parkinsonism, restless legs syndrome, seizure, speech disorder, syncope, tardive dyskinesia, tremor

Uncommon (0.1% to 1%): Amnesia, cerebrovascular accident, hemiplegia, hyperkinesia, involuntary movements, migraine, myoclonus, stupor, taste perversion, vertigo

Rare (0.01% to 0.1%): Aphasia, cerebral ischemia, choreoathetosis, neuralgia, neuroleptic malignant syndrome (NMS), subdural hematoma

Frequency not reported: Stroke

Postmarketing reports: Cerebrovascular accident, retrograde amnesia

XR/XL Tablets:

Very common (10% or more): Somnolence (up to 53%), sedation (up to 31.9%), dizziness (up to 18%), headache (up to 17.5%), extrapyramidal symptoms (up to 11.2%)

Common (1% to 10%): Akathisia, disturbance in attention, dysarthria, dyskinetic event, dystonic event, hypersomnia, lethargy, mental impairment, migraine, other extrapyramidal event, paresthesia, parkinsonism, restless legs syndrome, sinus headache, syncope, tremor, vertigo

Uncommon (0.1% to 1%): Seizure, tardive dyskinesia

Rare (0.01% to 0.1%): NMS

Frequency not reported: Akinesia, cerebrovascular adverse reactions, choreoathetosis, cognitive impairment, cogwheel rigidity, drooling, dyskinesia, dystonia, extrapyramidal disorder, hypertonia, hypokinesia, motor impairment, movement disorder, parkinsonian gait, psychomotor agitation, psychomotor hyperactivity, stroke

Postmarketing reports: Cerebrovascular accident, retrograde amnesia[Ref]

Somnolence usually occurred during the first 2 weeks and resolved with continued therapy.[Ref]

Metabolic

Atypical antipsychotic drugs have been associated with metabolic changes that include hyperglycemia/diabetes mellitus, dyslipidemia, and weight gain. While these effects have been shown as a class effect, each agent has its own profile.

Hyperglycemia: Adults: In controlled clinical trials of 12 weeks or less, 2.4% of patients with normal (less than 100 mg/dL) fasting plasma glucose (FPG) had at least 1 FPG reading of 126 mg/dL or greater (vs. placebo 1.4%) during treatment. For patients with baseline borderline to high FPG (100 mg/dL or higher), 11.7% had at least 1 FPG reading of 126 mg/dL or greater (vs. placebo, 11.8%). In 2 longer-term trials, the mean change in blood glucose from baseline in patients treated with this drug (mean exposure 213 days; n=646) was 5 mg/dL (vs. placebo -0.05 mg/dL). Among patients with major depressive disorder receiving the extended-release formulation of this drug, a FBG greater than 126 mg/dL occurred in 7%, 12%, and 6% of those receiving 150 mg, 300 mg, or placebo. In a study of patients 10 to 17 years old with bipolar mania, the mean change in fasting glucose was 3.62 mg/dL (n=170). No patients with a baseline fasting glucose level lower than 126 mg/dL had a treatment-emergent blood glucose level greater than 126 mg/dL.

Dyslipidemia: Across indications, adult patients who experienced shifts in total cholesterol, triglycerides, LDL-cholesterol, and HDL-cholesterol from baseline to clinically significant levels occurred in up to 18%, 22%, 6%, and 14% of patients receiving this drug compared with up to 7%, 16%, 5%, and 14% receiving placebo, respectively. For pediatric patients, the shifts were up to 12%, 22%, 8%, and 15% compared to up to 3%, 13%, 5%, and 19% for this drug and placebo, respectively.

Weight gain: Logistic regression analysis has shown a positive dose response for weight gain. Five to 10% of adult patients experienced a weight gain of 7% or greater (vs. up to 5% in placebo). Among children and adolescents, a weight gain of 7% or greater occurred in 7% to 21% of patients receiving this drug compared with up to 7% in placebo patients. Mean change in body weight was 1.7 to 2 kg in 3- to 6-week trials and 4.4 kg in 26-week trials. These results were not adjusted for normal growth.[Ref]

IR Formulations:

Very common (10% or more): Weight gain (up to 45%), elevated triglycerides (up to 23%), decreased fasting high-density lipoprotein (HDL) cholesterol (up to 18.3%), total cholesterol elevations (up to 16%), increased appetite (up to 10%)

Common (1% to 10%): Anorexia, blood glucose increased to hyperglycemic levels, thirst

Uncommon (0.1% to 1%): Alcohol intolerance, alkaline phosphatase increased, dehydration, diabetes mellitus, exacerbation of pre-existing diabetes, hyperglycemia, hyperlipidemia, hypoglycemia, hyponatremia, weight loss

Rare (0.01% to 0.1%): Gout, hypokalemia, metabolic syndrome, water intoxication

XR/XL Tablets:

Very common (10% or more): Triglyceride elevations (up to 18%), total cholesterol elevations (up to 17%), increased appetite (up to 12%)

Common (1% to 10%): Blood glucose increased to hyperglycemic levels, decreased appetite, increased blood glucose, weight gain/weight increased

Uncommon (0.1% to 1%): Diabetes mellitus, exacerbation of pre-existing diabetes, hyponatremia

Rare (0.01% to 0.1%): Metabolic syndrome[Ref]

Gastrointestinal

Logistic regression analysis has shown a positive dose response for dyspepsia and abdominal pain.[Ref]

IR Formulations:

Very common (10% or more): Dry mouth (up to 44%), vomiting (up to 10.8%), constipation (up to 10%), nausea (up to 10%)

Common (1% to 10%): Abdominal pain, diarrhea, dyspepsia, dysphagia, gastroenteritis, gastroesophageal reflux disease (GERD), stomach discomfort, stomatitis, tooth abscess

Uncommon (0.1% to 1%): Fecal incontinence, flatulence, gastritis, gingivitis, gum hemorrhage, hemorrhoids, increased salivation, rectal hemorrhage, tongue edema, tooth caries, mouth ulceration

Rare (0.01% to 0.1%): Abdomen enlarged, buccoglossal syndrome, glossitis, hematemesis, intestinal ileus, intestinal obstruction, melena, pancreatitis

XR/XL Tablets:

Very common (10% or more): Dry mouth (up to 40%), nausea (up to 13.3%), constipation (up to 11%)

Common (1% to 10%): Diarrhea, dyspepsia, toothache, viral gastroenteritis, vomiting

Uncommon (0.1% to 1%): Dysphagia

Rare (0.01% to 0.1%): Intestinal ileus, intestinal obstruction, pancreatitis[Ref]

Other

IR Formulations:

Very common (10% or more): Asthenia (up to 17.6%), fatigue (up to 14%)

Common (1% to 10%): Accidental overdose, ear pain, fever, heaviness, mild asthenia, pain, pyrexia

Uncommon (0.1% to 1%): Abnormal gait, chills, malaise, tinnitus

Rare (0.01% to 0.1%): Hypothermia, deafness

Frequency not reported: Falls, increased mortality

XR/XL Tablets:

Very common (10% or more): Fatigue (up to 14%)

Common (1% to 10%): Ear pain, fall, mild asthenia, pyrexia, sluggishness

Rare (0.01% to 0.1%): Hypothermia

Frequency not reported: Increased mortality[Ref]

Psychiatric

IR Formulations:

Very common (10% or more): Agitation (up to 20%), discontinuation symptoms (up to 16%)

Common (1% to 10%): Abnormal dreams, aggression, anxiety, depression, insomnia, irritability, nightmares, suicidal behavior, suicidal ideation, suicide-related events, thinking abnormal

Uncommon (0.1% to 1%): Apathy, bruxism, catatonic reaction, confusion, delusions, depersonalization, hallucinations, libido increased, manic reaction, paranoid reaction, psychosis, suicide attempt

Rare (0.01% to 0.1%): Delirium, emotional lability, euphoria, libido decreased, neonatal withdrawal, sleep-related eating disorder, sleep talking, somnambulism and other related events, stuttering

Frequency not reported: Drug withdrawal syndrome neonatal

Postmarketing reports: Nocturnal enuresis

XR/XL Tablets:

Common (1% to 10%): Abnormal dreams, anxiety, confusional state, depression, discontinuation/withdrawal symptoms, disorientation, insomnia, irritability, libido decreased, nightmares, restlessness, schizophrenia, suicidal behavior, suicidal ideation, suicide-related events

Rare (0.01% to 0.1%): Sleep-related eating disorder, sleep talking, somnambulism and related reactions

Frequency not reported: Drug withdrawal syndrome neonatal

Postmarketing reports: Nocturnal enuresis[Ref]

Cardiovascular

Collective data gathered from 17 placebo-controlled clinical studies (n=5106) involving the use of atypical antipsychotic agents, including this drug, for the treatment of behavioral disorders in the elderly patient with dementia showed a risk of death 1.6 to 1.7 times greater in the drug treated patient than in the placebo treated patient. The average length of duration for the trials was 10 weeks with the cause of death in the majority of cases, though not all, reported as either cardiovascular (e.g., heart failure, sudden death) or infectious (e.g., pneumonia) in nature. Similar results (i.e., increased risk of mortality with atypical antipsychotics) were reported in another meta-analysis involving elderly dementia patients that consisted of 15 randomized, placebo-controlled trials (n=3353) of 10 to 12 weeks in duration. This drug should not be used to treat behavioral disorders in elderly patients with dementia.

An increased risk of mortality, possibly due to heart failure or sudden death, has been reported with the use of atypical antipsychotic agents in the treatment of behavioral disorders in the elderly patient with dementia.

The results of a large retrospective cohort study appear to indicate that atypical antipsychotic agents (e.g., clozapine, olanzapine, risperidone, this drug) increase the risk of venous thromboembolism in elderly patients; however, these events seem to be rare.

Blood pressure elevations described as systolic elevations of 20 mmHg or greater and diastolic elevations of 10 mmHg or greater were observed in 15.2% and 40.6% of children and adolescents, respectively. A child with a history of hypertension experienced a hypertensive crisis.

QT intervals have not been systematically evaluated. During clinical trials, persistent increases in QT intervals were not identified; however there have been postmarketing reports of QT prolongation in patients who overdosed on this drug, in patients with concomitant illness, and in patients taking drugs that are known to cause electrolyte imbalance or QT interval prolongation.[Ref]

Immediate-Release (IR) Formulations:

Very common (10% or more): Postural hypotension (up to 12.2%), tachycardia (up to 11%)

Common (1% to 10%): Hypotension, hypertension, increased blood pressure, orthostatic hypotension, pallor, palpitations, peripheral edema, sinus tachycardia

Uncommon (0.1% to 1%): Bradycardia, bundle branch block, cyanosis, deep thrombophlebitis, irregular pulse, QT interval prolonged, T wave abnormality, T wave inversion, vasodilation

Rare (0.01% to 0.1%): Angina pectoris, atrial fibrillation, atrioventricular (AV) block first degree, congestive heart failure, hand edema, increased QRS duration, ST abnormality, ST elevated, thrombophlebitis, T wave flattening, venous thromboembolism

Postmarketing reports: Cardiomyopathy, myocarditis

Extended-Release (XR)/Prolonged-release (XL) Tablets:

Common (1% to 10%): Heart rate increased, hypotension, increases in blood pressure, orthostatic hypotension, palpitations, peripheral edema, tachycardia

Uncommon (0.1% to 1%): Bradycardia, QT prolongation

Rare (0.01% to 0.1%): Venous thromboembolism

Postmarketing reports: Cardiomyopathy, myocarditis[Ref]

Hematologic

IR Formulations:

Very common (10% or more): Decreased hemoglobin (Up to 11%)

Common (1% to 10%): Decreased neutrophil count, eosinophils increased, leukopenia, neutropenia

Uncommon (0.1% to 1%): Anemia, eosinophilia, hypochromic anemia, leukocytosis, lymphadenopathy, platelet count decreased, severe neutropenia, thrombocytopenia

Rare (0.01% to 0.1%): Agranulocytosis, hemolysis

XR/XL Tablets:

Very common (10% or more): Decreased hemoglobin (up to 11%)

Common (1% to 10%): Decreased neutrophil count, eosinophils increased, leukopenia

Uncommon (0.1% to 1%): Anemia, neutropenia, platelet count decreased, thrombocytopenia

Rare (0.01% to 0.1%): Agranulocytosis[Ref]

Respiratory

IR Formulations:

Common (1% to 10%): Cough, cough increased, dyspnea, epistaxis, nasal congestion, nasopharyngitis, pharyngitis, rhinitis, sinus congestion, sinusitis, upper respiratory tract infection

Uncommon (0.1% to 1%): Asthma, pneumonia

Rare (0.01% to 0.1%): Hiccup, hyperventilation

XR/XL Tablets:

Common (1% to 10%): Dyspnea, nasal congestion, nasopharyngitis, sinus congestion, sinusitis, upper respiratory tract infection

Uncommon (0.1% to 1%): Rhinitis[Ref]

Endocrine

IR Formulations:

Common (1% to 10%): Decreased total T3, decreased free T4, decreased total T4, hormone levels altered, hyperprolactinemia, hypothyroidism, increased thyroid stimulating hormone (TSH), serum prolactin elevations

Uncommon (0.1% to 1%): Decreased free T3

Rare (0.01% to 0.1%): Gynecomastia, hyperthyroidism

Postmarketing reports: Syndrome of inappropriate antidiuretic hormone secretion (SIADH)

XR/XL Tablets:

Common (1% to 10%): Decreased free T4, decreased total T3, decreased total T4, elevations in serum prolactin, hyperprolactinemia, increased TSH

Uncommon (0.1% to 1%): Decreased free T3, hypothyroidism

Very rare (less than 0.01%): SIADH[Ref]

In adults, dose-related decreases in thyroid hormone levels have been observed. It appears that maximal reductions in total and free thyroxine (T4) occur in the first 6 weeks of treatment and are maintained without adaptation or progression during chronic therapy. Upon therapy discontinuation, these effects mostly return to baseline values. The mechanism by which this drug affects the thyroid axis is unclear.[Ref]

Musculoskeletal

IR Formulations:

Common (1% to 10%): Arthralgia, back pain, muscle rigidity, musculoskeletal stiffness, pain in extremity, twitching

Uncommon (0.1% to 1%): Arthritis, bone pain, leg cramps, neck pain, myasthenia, pathological fracture

Rare (0.01% to 0.1%): Elevations in blood creatine phosphokinase

Very rare (less than 0.01%): Rhabdomyolysis

XR/XL Tablets:

Common (1% to 10%): Arthralgia, back pain, muscle spasms, myalgia, neck pain

Rare (0.01% to 0.1%): Elevations in blood creatine phosphokinase

Very rare (less than 0.01%): Rhabdomyolysis

Frequency not reported: Muscle rigidity, neck rigidity, nuchal rigidity[Ref]

Hepatic

IR Formulations:

Common (1% to 10%): ALT increased, AST increased, GGT increased

Rare (0.01% to 0.1%): Hepatitis, jaundice

Postmarketing reports: Cholestatic liver injury, hepatic failure/fatal hepatic failure, hepatic steatosis, mixed liver injury

XR/XL Tablets:

Common (1% to 10%): Elevations in ALT, elevations in GGT, transaminase elevations

Uncommon (0.1% to 1%): Elevations in AST

Rare (0.01% to 0.1%): Hepatitis, jaundice

Postmarketing reports: Cholestatic liver injury, hepatic failure/fatal hepatic failure, hepatic steatosis, mixed liver injury[Ref]

Dermatologic

IR Formulations:

Common (1% to 10%): Acne, rash, sweating

Uncommon (0.1% to 1%): Allergic skin reactions, contact dermatitis, ecchymosis, eczema, face edema, maculopapular rash, photosensitivity reaction, pruritus, seborrhea, skin ulcer

Rare (0.01% to 0.1%): Exfoliative dermatitis, psoriasis, skin discoloration

Very rare (less than 0.01%): Stevens-Johnson syndrome (SJS)

Frequency not reported: Drug reaction with eosinophilia and systemic symptoms (DRESS), erythema multiforme, toxic epidermal necrolysis (TEN)

XR/XL Tablets:

Common (1% to 10%): Hyperhidrosis

Uncommon (0.1% to 1%): Allergic skin reactions

Very rare (less than 0.01%): SJS

Frequency not reported: DRESS, erythema multiforme, TEN[Ref]

Immunologic

IR Formulations:

Common (1% to 10%): Flu syndrome, infection

Uncommon (0.1% to 1%): Moniliasis

XR/XL Tablets:

Common (1% to 10%): Influenza, seasonal allergy[Ref]

Ocular

IR Formulations:

Common (1% to 10%): Amblyopia, vision blurred

Uncommon (0.1% to 1%): Abnormal vision, blepharitis, conjunctivitis, dry eyes, eye pain

Rare (0.01% to 0.1%): Abnormality of accommodation, glaucoma

Postmarketing reports: Cataract

XR/XL Tablets:

Common (1% to 10%): Vision blurred

Frequency not reported: Oculogyration

Postmarketing reports: Cataract[Ref]

Genitourinary

IR Formulations:

Common (1% to 10%): Urinary tract infection

Uncommon (0.1% to 1%): Abnormal ejaculation, amenorrhea, cystitis, dysmenorrhea, dysuria, female lactation, impotence, leukorrhea, metrorrhagia, orchitis, pelvic pain, sexual dysfunction, urinary frequency, urinary incontinence, urinary retention, vaginal hemorrhage, vaginal moniliasis, vaginitis, vulvovaginitis

Rare (0.01% to 0.1%): Breast swelling, galactorrhea, menstrual disorder, nocturia, polyuria, priapism

XR/XL Tablets:

Common (1% to 10%): Pollakiuria

Uncommon (0.1% to 1%): Sexual dysfunction, urinary retention

Rare (0.01% to 0.1%): Breast swelling, galactorrhea, menstrual disorder, priapism[Ref]

Hypersensitivity

IR Formulations:

Uncommon (0.1% to 1%): Hypersensitivity

Very rare (less than 0.01%): Anaphylactic reaction, angioedema

XR/XL Tablets:

Uncommon (0.1% to 1%): Hypersensitivity

Very rare (less than 0.01%): Anaphylactic reaction, angioedema[Ref]

Renal

Incidence not known

- Aching or discomfort in the lower legs or sensation of crawling in the legs
- agitation
- bed-wetting
- blistering, peeling, or loosening of the skin
- bloating
- bluish lips or skin
- chest discomfort
- constipation
- dark urine
- decreased awareness or responsiveness
- decreased urine output
- depression
- diarrhea
- difficulty breathing
- difficulty in passing urine (dribbling)
- difficulty swallowing
- dizziness
- faintness
- general feeling of tiredness or weakness
- headache
- hives, itching, skin rash
- hoarseness
- increased thirst
- indigestion
- irritability

- shuffling walk
- slowed movements
- slurred speech
- sore throat
- sores, ulcers, or white spots on the lips or in the mouth
- sticking out of the tongue
- stiffness of the arms or legs
- sweating
- swelling of the face, arms, hands, feet, or lower legs
- swollen glands
- trembling and shaking of the hands and fingers
- trouble with breathing, speaking, or swallowing
- uncontrolled chewing movements
- uncontrolled movements of the arms and legs
- uncontrolled twisting movements of the neck, trunk, arms, or legs
- unusual bleeding or bruising
- unusual facial expressions
- unusual tiredness or weakness

Rare

- Dry, puffy skin
- fast, pounding, or irregular heartbeat
- loss of appetite
- menstrual changes
- unusual secretion of milk (in females)
- weight gain

- trouble recognizing objects
- trouble sleeping
- trouble thinking and planning
- trouble walking
- unusual bleeding or bruising
- unusual tiredness or weakness
- unusual weight gain or loss
- vomiting

Less common

- Abnormal dreams
- absence of or decrease in body movement
- anxiety
- bloody nose
- blurred vision
- bruising burning, crawling, itching, numbness, prickling, "pins and needles", or tingling feelings
- change in personality
- change in walking and balance
- changes in patterns and rhythms of speech
- chest pain
- cloudy urine
- clumsiness or unsteadiness
- cold sweats
- constipation
- dark urine
- deep or fast breathing with dizziness

- headache
- hoarseness
- joint pain
- loss of appetite
- lower back or side pain
- mental depression
- muscle aches and pains
- nausea
- nervousness
- painful or difficult urination
- pinpoint red spots on the skin
- poor insight and judgment
- problems with memory or speech
- quick to react or overreact emotionally
- rapid weight gain
- rapidly changing moods
- runny nose
- sense of detachment from self or body
- shakiness in the legs, arms, hands, or feet
- shivering
- sleepiness or unusual drowsiness
- sore throat
- sweating
- tightness in the chest
- tingling of the hands or feet
- trembling or shaking of the hands or feet

Postmarketing reports: Paradoxical convulsion, parkinsonism[Ref]

Hematologic

Very common (10% or more): Thrombocytopenia

Common (1% to 10%): Anemia, hemorrhage

Uncommon (0.1% to 1%): Leucopenia, pancytopenia

Rare (less than 0.1%): Abnormal coagulation tests (e.g., prolonged prothrombin time, prolonged activated partial thromboplastin time, prolonged thrombin time, prolonged INR), agranulocytosis, bone marrow failure, decreased coagulation factors, including pure red cell aplasia, macrocytosis

Frequency not reported: Aplastic anemia, bone marrow suppression, bruising, eosinophilia, frank hemorrhage, hypofibrinogenemia, anemia including macrocytic with or without folate deficiency, relative lymphocytosis

Postmarketing reports: Relative lymphocytosis, macrocytosis, leukopenia, anemia including macrocytic with or without folate deficiency, bone marrow suppression, pancytopenia, aplastic anemia, agranulocytosis, acute intermittent porphyria, Fanconi's syndrome (mostly children)[Ref]

Respiratory

Very common (10% or more): Flu syndrome, respiratory infection

Common (1% to 10%): Bronchitis, dyspnea, epistaxis, increased cough, pharyngitis, pneumonia, rhinitis, sinusitis

Uncommon (0.1% to 1%): Pleural effusion[Ref]

Renal

Rare (less than 0.1%): Reversible Fanconi's syndrome, tubulointerstitial nephritis[Ref]

Cardiovascular

Common (1% to 10%): Edema, hypertension, hypotension, palpitations, postural hypotension, peripheral edema, tachycardia, vasodilation

Frequency not reported: Bradycardia, cutaneous vasculitis, hematoma formation

Postmarketing reports: Bradycardia, cutaneous vasculitis[Ref]

Psychiatric

- increased hair growth, especially on the face
- unexpected or excess milk flow from the breasts

For Healthcare Professionals

Applies to divalproex sodium: **oral delayed release capsule, oral delayed release tablet, oral tablet extended release**.

General

The more commonly reported adverse reactions have included headache, asthenia, nausea/vomiting, abdominal pain, somnolence, tremor, dizziness, diplopia, and amblyopia/blurred vision.

Gastrointestinal

Very common (10% or more): Abdominal pain, diarrhea, dyspepsia, gingival disorder, nausea, vomiting

Common (1% to 10%): Constipation, dry mouth, eructation, fecal incontinence, flatulence, gastralgia, gastroenteritis, glossitis, periodontal abscess, hematemesis, stomatitis

Uncommon (0.1% to 1%): Pancreatitis (life-threatening)[Ref]

Hepatic

Common (1% to 10%): Increased liver enzymes (particularly early in treatment), liver injury, SGOT increased, SGPT increased

Frequency not reported: Severe liver damage (including hepatic failure sometimes resulting in death), increased serum bilirubin, abnormal changes in other liver function tests[Ref]

Nervous system

Very common (10% or more): Dizziness, headache, somnolence, tremor

Common (1% to 10%): Abnormal gait, amnesia, catatonic reaction, convulsion, disturbance in attention, dysarthria, extrapyramidal disorder, hypertonia, hypokinesia, incoordination, increased reflexes, memory impairment, nystagmus, paresthesia, speech disorder, stupor, tardive dyskinesia, taste perversion

Uncommon (0.1% to 1%): Ataxia, coma, encephalopathy, lethargy, reversible Parkinsonism

Rare (less than 0.1%): Cognitive disorder, reversible dementia associated with reversible cerebral atrophy

Frequency not reported: Cerebral atrophy, dementia

- eye pain
- feeling of constant movement of self or surroundings
- full feeling
- heavy bleeding
- increased appetite
- itching of the vagina or genital area
- loss of bowel control
- neck pain
- oily skin
- pain
- pain during sexual intercourse
- pain or tenderness around the eyes and cheekbones
- passing gas
- rash with flat lesions or small raised lesions on the skin
- redness or swelling in the ear
- redness, pain, swelling of the eye, eyelid, or inner lining of the eyelid
- redness, swelling, or soreness of the tongue
- sensation of spinning
- sneezing
- stiff neck
- stopping of menstrual bleeding
- thick, white vaginal discharge with no odor or with a mild odor

Incidence not known

- Breast enlargement
- changes in hair color or texture
- discoloration of the fingernails or toenails

- continuing ringing or buzzing or other unexplained noise in the ears
- hair loss or thinning of the hair
- hearing loss
- heartburn
- impaired vision
- lack or loss of strength
- loss of memory
- problems with memory
- seeing double
- tender, swollen glands in the neck
- uncontrolled eye movements
- voice changes
- weight gain
- weight loss

Less common

- Absent, missed, or irregular menstrual periods
- burning, dry, or itching eyes
- change in taste or bad unusual or unpleasant (after) taste
- coin-shaped lesions on the skin
- cough producing mucus
- cramps
- dandruff
- discharge or excessive tearing
- dry skin
- earache
- excess air or gas in the stomach or bowels

Common (1% to 10%): Amenorrhea, cystitis, dysmenorrhea, dysuria, enuresis, metrorrhagia, urinary incontinence, urinary frequency, vaginal hemorrhage, vaginitis

Frequency not reported: Breast enlargement, galactorrhea, polycystic ovary disease

Postmarketing reports: Irregular menses, secondary amenorrhea, polycystic ovary disease, aspermia, azoospermia, decreased sperm count, decreased spermatozoa motility, male infertility, abnormal spermatozoa morphology, enuresis, urinary tract infection[Ref]

Hypersensitivity

Frequency not reported: Allergic reaction, anaphylaxis, hypersensitivity[Ref]

Metabolic

Very common (10% or more): Anorexia

Common (1% to 10%): Weight loss/gain, increased appetite, hyponatremia

Rare (less than 0.1%): Hyperammonemia

Frequency not reported: Acute intermittent porphyria, minor elevations of LDH (dose related), decreased carnitine concentrations, hyperglycinemia

Postmarketing reports: Decreased carnitine concentrations, hyponatremia, hyperglycinemia, weight gain[Ref]

Musculoskeletal

Common (1% to 10%): Arthralgia, arthrosis, leg cramps, myalgia, myasthenia, twitching

Uncommon (0.1% to 1%): Decreased bone mineral density, osteopenia, osteoporosis and fractures on long term therapy

Rare (less than 0.1%): Rhabdomyolysis, systemic lupus erythematosus

Frequency not reported: Bone pain

Postmarketing reports: Fractures, decreased bone mineral density, osteopenia, osteoporosis, weakness, bone pain[Ref]

Ocular

Very common (10% or more): Amblyopia/blurred vision, diplopia

Common (1% to 10%): Abnormal vision, conjunctivitis, diplopia, dry eyes, eye pain[Ref]

Very common (10% or more): Nervousness

Common (1% to 10%): Abnormal dreams, agitation, anxiety, aggression, confusion, depression, emotional lability, hallucinations, insomnia, personality disorder, thinking abnormalities

Rare (less than 0.1%): Abnormal behavior, learning disorder, psychomotor hyperactivity

Frequency not reported: Behavioral deterioration, hostility, psychosis

Postmarketing reports: Emotional upset, psychosis, aggression, psychomotor hyperactivity, hostility, disturbance in attention, learning disorder, behavioral deterioration[Ref]

Endocrine

Uncommon (0.1% to 1%): Hyperandrogenism, syndrome of inappropriate ADH secretion

Rare (less than 0.1%): Hypothyroidism

Frequency not reported: Abnormal thyroid function tests, elevated serum testosterone concentrations, parotid gland swelling

Postmarketing reports: Hyperandrogenism, hirsutism, elevated testosterone level, breast enlargement, galactorrhea, parotid gland swelling, inappropriate ADH secretion, developmental delay[Ref]

Dermatologic

Very common (10% or more): Alopecia

Common (1% to 10%): Discoid lupus erythematosus, dry skin, ecchymosis, furunculosis, maculopapular rash, petechia, pruritus, rash, seborrhea

Uncommon (0.1% to 1%): Abnormal hair texture, abnormal hair growth, hair color changes, sweating

Rare (0.01% to 0.1%): Drug rash with eosinophilia and systemic symptoms (DRESS) syndrome, erythema multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis

Very rare (less than 0.01%): Acne, hirsutism

Frequency not reported: Angioedema, generalized pruritus, photosensitivity

Postmarketing reports: Hair texture changes, hair color changes, photosensitivity, erythema multiforme, toxic epidermal necrolysis, nail and nail bed disorders, Stevens-Johnson syndrome[Ref]

Genitourinary

Oncologic

Rare (less than 0.1%): Myelodysplastic syndrome[Ref]

Other

Very common (10% or more): Asthenia

Common (1% to 10%): Back pain, chills, deafness, ear disorder, ear pain, face edema, fever, malaise, otitis media, tinnitus, vertigo

Frequency not reported: Hypothermia, weakness

Postmarketing reports: Hearing loss[Ref]

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Further information

Always consult your healthcare provider to ensure the information displayed on this page applies to your personal circumstances.

Some side effects may not be reported. You may report them to the FDA.

Table 1

Clinical Decision Steps in Bipolar Diagnosis

1. Establish whether the presenting symptoms raise a suspicion of bipolar disorder
2. Employ case-finding tools to support the preliminary diagnosis of bipolar disorder
3. Conduct a detailed clinical interview that comprehensively covers the patient's medical and family history—together with relevant physical examinations and laboratory tests—to confirm the bipolar diagnosis, identify comorbid medical conditions, and exclude alternative diagnoses

Table 2

Manic and Hypomanic Episodes: *DSM-5* Criteria[a]

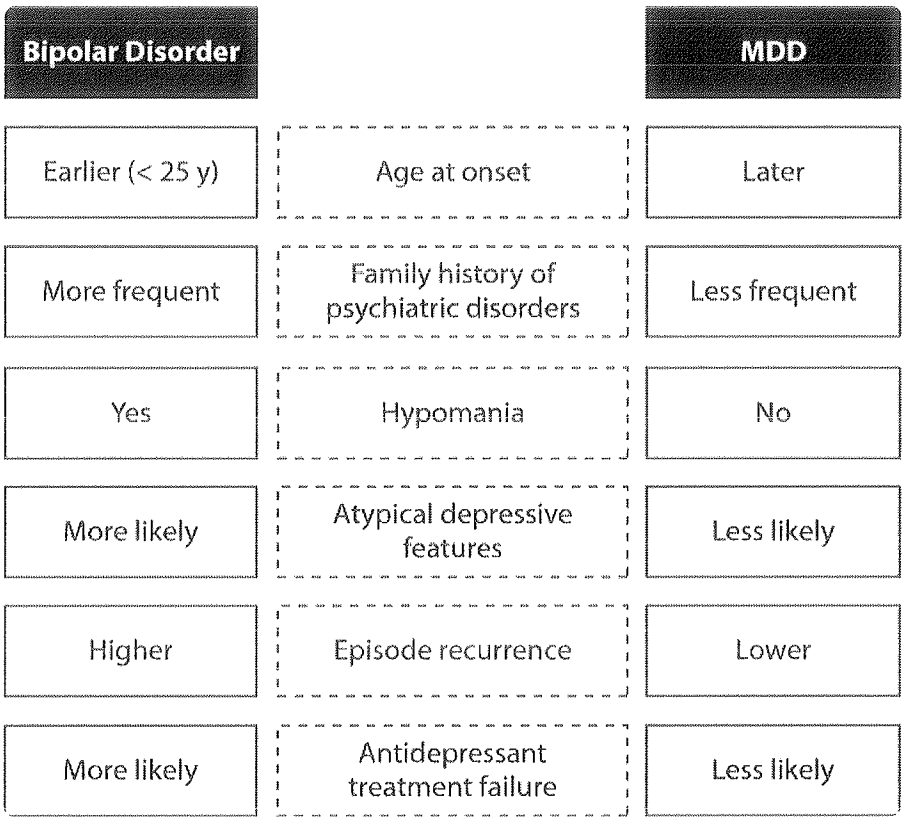
Table 4

The Mood Disorder Questionnaire[a]

Please answer each question to the best of your ability	
1. Has there ever been a period of time when you were not your usual self and...	
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	Yes/No
...you were so irritable that you shouted at people or started fights or arguments?	Yes/No
...you felt much more self-confident than usual?	Yes/No
...you got much less sleep than usual and found you didn't really miss it?	Yes/No
...you were much more talkative or spoke much faster than usual?	Yes/No
...thoughts raced through your head or you couldn't slow your mind down?	Yes/No
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes/No
...you had much more energy than usual?	Yes/No
...you were much more active or did many more things than usual?	Yes/No
...you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?	Yes/No
...you were much more interested in sex than usual?	Yes/No
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes/No
...spending money got you or your family into trouble?	Yes/No
2. If you checked YES to more than 1 of the above, have several of these ever happened during the same period of time?	Yes/No
3. How much of a problem did any of these cause you—being unable to work; having family, money, or legal troubles; getting into arguments or fights? Please circle 1 response only	
No problem Minor problem Moderate problem Serious problem	
Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	Yes/No
For a positive screen, 7 of the 13 items in no. 1 must be yes, no. 2 must be yes, and no. 3 must be moderate or serious	

[a]Adapted with permission from Hirschfeld et al.[22]

Figure 2



Key Differentiating Features of Depressive Symptoms in Bipolar Disorder Versus Major Depressive Disorder (MDD)[a]

Table 3

Major Depressive Episode: *DSM-5* Criteria[a]

Criteria A–C Constitute a Major Depressive Episode
Note: the *DSM-5* diagnostic criteria are the same for major depressive disorder and for depressive episodes of bipolar disorder
A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from the previous functioning; at least 1 of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure
(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (eg, feels sad, empty, or hopeless) or observation made by others (eg, appears tearful) (Note: in children and adolescents, can be irritable mood)
(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
(3) Significant weight loss when not dieting or weight gain (eg, a change of more than 5% of body weight in a month) or decrease or increase in appetite nearly every day
(4) Insomnia or hypersomnia nearly every day
(5) Psychomotor agitation or retardation nearly every day (observable by others; not merely subjective feelings of restlessness or being slowed down)
(6) Fatigue or loss of energy nearly every day
(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicidal attempt or a specific plan for committing suicide
B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
C. Episode is not attributable to the physiologic effects of a substance or to another medication
Major depressive episodes are common in bipolar disorder, but are not required for a diagnosis of bipolar I disorder. Criteria for a past or current hypomanic episode and a past or current major depressive episode are required for a diagnosis of bipolar II disorder

[a]Reprinted with permission from American Psychiatric Association.[5]

Manic Episode

Criteria A–D constitute a manic episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary)

Note: In *DSM-5* versus *DSM-IV*, Criterion A is revised to include increased energy/activity as a core symptom

B. During the period of mood disturbance and increased energy or activity, 3 (or more) of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

(1) Inflated self-esteem or grandiosity

(2) Decreased need for sleep (eg, feels rested after only 3 hours of sleep)

(3) More talkative than usual or pressure to keep talking

(4) Flight of ideas or subjective experience that thoughts are racing

(5) Distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed

(6) Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (ie, purposeless non–goal-directed activity)

(7) Excessive involvement in activities that have a high potential for painful consequences (eg, engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features

D. The episode is not attributable to the physiologic effects of a substance (eg, a drug of abuse, a medication, other treatment) or to another medication

At least 1 lifetime manic episode is required for a diagnosis of bipolar I disorder

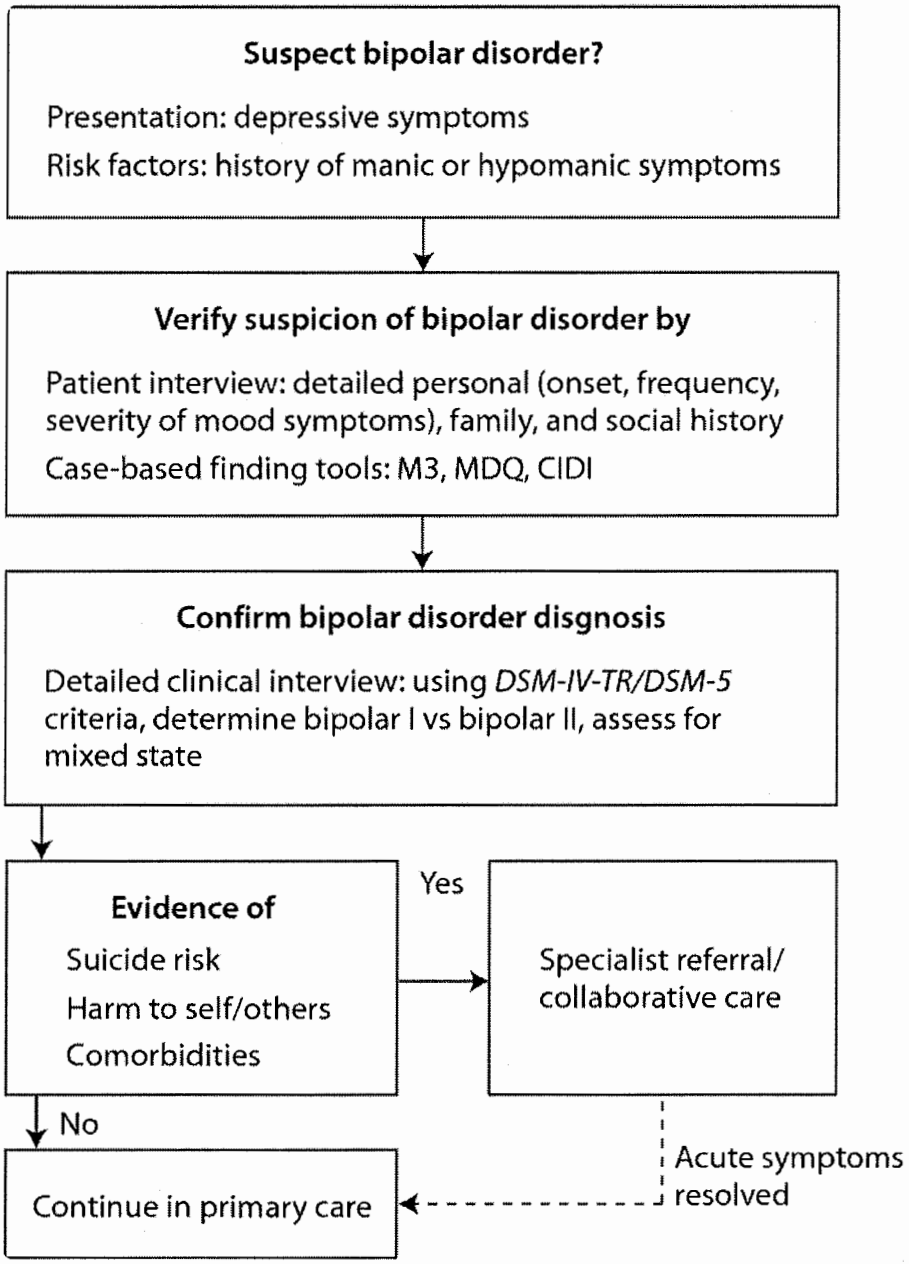
Hypomanic Episode

Criteria A–F constitute a hypomanic episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day

[a]Reprinted with permission from American Psychiatric Association.[5]

Figure 1



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CONCLUSION

Primary care physicians are the initial as well as the continued point of contact for many patients with bipolar disorder, with responsibility for accurate diagnosis and appropriate ongoing care. Diagnostic accuracy can be improved by attentiveness to the key symptoms and signs of bipolar disorder. Pharmacologic and psychosocial treatments can provide effective management for manic and depressive symptoms and maintain remission over the long term in many patients.

As with any chronic illness, the objective of working with bipolar patients to improve their adaptive and problem-solving skills and their self-management and self-monitoring skills should be a priority. Ensuring that both patient and family are familiar with local and national support networks will also be helpful.

Whether they manage bipolar patients directly or refer them to specialist psychiatric care, primary care physicians are vital to the long-term management of these patients, both through reengaging them with therapy for future mood episodes and in ensuring that they obtain quality preventive and chronic disease care.

Drug names: aripiprazole (Abilify), asenapine (Saphris), carbamazepine (Carbatrol, Equetro, and others), divalproex (Depakote and others), fluoxetine (Prozac and others), lamotrigine (Lamictal and others), lithium (Lithobid and others), lurasidone (Latuda), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal and others), ziprasidone (Geodon).

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it is important to "treat the disease, don't blame the patient"). Given the high frequency of coexisting medical conditions in bipolar disorder, routine monitoring should include an evaluation for medical morbidities.[2,55,59]

Patient and family education has been shown to enhance the success of goal-setting, decision-making, and collaboration with the health care team, thereby increasing the likelihood of an improved long-term outcome.[52] In particular, educating patients on how to monitor their symptoms for signs of impending relapse can assist physicians in monitoring and management (Table 12).[50,98] Patient-directed educational resources are widely available to support health care professionals in this regard.[99,100]

Adherence

The primary care physician has a fundamental role in encouraging adherence. Nonadherence to medication is an acknowledged barrier to effective treatment over the long term.[101] Discussion of the treatment options available and their possible adverse effects (and how to manage them) can enhance treatment adherence. Patients may give many reasons for nonadherence to medication, but a common underlying reason is a lack of insight into the impact of symptom recurrence.[101,102] Encouraging patient education and forging a therapeutic alliance between physician and patient helps to maintain adherence to therapy.[103,104]

Psychosocial Treatments

While outside the remit of this review, psychosocial treatments—psychoeducation, cognitive-behavioral therapy, family-focused therapy, and interpersonal and social rhythm therapy—have an established role in management, with efficacy in regularizing daily activities, reducing substance misuse, identifying early warning signs of relapse, and enhancing medication adherence.[105]

General Medical Care

Patients with bipolar disorder have an increased incidence of certain medical comorbidities and are at elevated risk of early death, particularly cardiovascular-related death.[40] Medications used in the treatment of bipolar disorder can cause weight gain, lipid abnormalities, and other long-term effects, which may exacerbate the propensity to medical complications.[106]

Bipolar patients are also at elevated risk of not following routine preventive health care measures. For this reason, preventive care tactics tailored to the individual patient, such as hepatitis immunization or long-term birth control methods, are the most appropriate. Because sleep changes may trigger (as well as be an indicator of) a change in mood states, interventions to improve sleep can be helpful in this population.

For women who are pregnant, it is essential that treatment is maintained to stabilize their mood. The choice of the treatment administered requires careful consideration, given the potential teratogenicity of medications including lithium, divalproex, and carbamazepine.[55]

Among the atypical antipsychotics, olanzapine, risperidone (long-acting injection), and aripiprazole are approved as monotherapies for maintenance treatment, while quetiapine and ziprasidone are approved in combination with lithium or divalproex for prevention of recurrence.[60,71,84,85] Combining a mood stabilizer and an antipsychotic agent generally provides superior relapse prevention compared to single agents alone.[86,87]

Adverse Effects of Pharmacologic Treatments

All primary care physicians, whether or not they participate in the management of bipolar symptoms, should be aware of the safety profiles of the medications used in bipolar disorder (Table 10).[55,56]

The potential of lithium to cause progressive renal insufficiency and fatalities through overdose should be considered when making long-term therapy choices,[88] as should the deleterious effects of lithium, divalproex, and carbamazepine during pregnancy.[55,88] A main concern with lamotrigine is the serious, although rare, side effect of Stevens-Johnson–like rash.[55]

The adverse effects of atypical antipsychotics differ between the individual agents.[55,89-92] Olanzapine is associated with a higher risk of weight gain, diabetes mellitus, and dyslipidemia than other antipsychotics.[89-91] Risperidone induces marked hyperprolactinemia, whereas other atypical antipsychotics have minimal or even favorable effects on prolactin.[93] Ziprasidone is reported to have a lower risk for weight gain, and quetiapine has a decreased risk for extrapyramidal symptoms relative to risperidone.[94]

Children and adolescents with bipolar disorder may be particularly vulnerable to the weight gain associated with olanzapine, as well as the extrapyramidal symptoms and metabolic changes reported with other atypical antipsychotics.[95]

Monitoring

Long-term monitoring for medication adverse effects is essential to ensure continued safety (Table 11).[2,55,62] As mentioned previously, the propensity to weight gain and dyslipidemia is particularly high for olanzapine, although other atypical antipsychotics carry some level of risk.[90,95] The presence of cardiometabolic factors may signal the impending development of metabolic syndrome (which also includes hyperglycemia and hypertension), a condition that is a precursor to diabetes and cardiovascular disease. Prevention of these metabolic disorders and related premature death warrants dedicated routine monitoring for weight gain, blood pressure, and increases in triglyceride and glucose levels.[2,96]

Physicians must also monitor patients closely for emergence of mania or psychosis, changes in functioning and disability, and subjective reports of depressive symptoms and quality of life.[97] A rapid reinitiation or modification to therapy may be required if prodromal symptoms (eg, sleep disruption, increased irritability, resumption of substance use) or full-blown episodes emerge (ie,

Administration (FDA)–approved medications for bipolar I depression, while only quetiapine is approved for bipolar II depression.[55] Lamotrigine showed a small but significant improvement in depressive symptoms compared with placebo in a pooled analysis of 5 acute randomized controlled trials,[67] but 4 of these 5 studies were underpowered and failed to show a superiority of lamotrigine over placebo.[68] The role of lamotrigine in the maintenance treatment and prevention of depressive episodes is more convincing, with 2 favorable, randomized, placebo-controlled trials that have led to FDA approval of lamotrigine for this indication.[69,70]

Quetiapine is the only medication that is FDA approved as monotherapy for the treatment of both manic and depressive episodes of bipolar disorder.[71] The extended-release (XR) formulation of quetiapine is approved for once-daily dosing for both manic and depressed episodes, while the immediate-release (IR) formulation of quetiapine is dosed twice daily for bipolar mania and once daily for bipolar depression.[72,73] A medication with broad-spectrum mood-stabilizing potential may offer opportunities for simplified therapy in specific patients.[74] It may also be noted that the XR formulation of quetiapine, aripiprazole, and lurasidone are the only atypical antipsychotics approved as adjunctive therapy in MDD.[73,75] Compared with the IR formulation, quetiapine XR offers the benefit of once-daily dosing in all approved indications, which is achieved through its distinct pharmacokinetic profile, characterized by a lower peak concentration and more stable plasma concentrations over time.[76] Quetiapine XR also has a distinct tolerability profile relative to the IR formulation, including a reduction in sedation intensity during initial dose escalation.[76–78]

Mixed features/mixed episodes. Divalproex and the atypical antipsychotics (aripiprazole, olanzapine, quetiapine XR, risperidone, ziprasidone, and asenapine) are recommended as first-line treatments for mixed states.[79] By contrast, lithium does not appear to confer significant benefit in mixed states.[2] Combination therapies, typically including an atypical antipsychotic and a mood stabilizer, are likely to be required for many patients experiencing mixed states.[79]

Maintenance Treatments

Maintenance treatment can reduce, although not entirely eliminate, the recurrence of mood episodes. In part, this limitation reflects the limited efficacy of medications, but, in part, it is also explained by poor adherence, which is encouraged by a suboptimal symptom response or the development of treatment-related adverse effects.[80,81]

In many patients, the medications that were effective for the acute phase are the first choice in maintenance treatment.[55] Lithium at optimal doses reduces the rate of recurrence by 50% in clinical trials.[63] The long-term benefits of lithium are hindered by poor adherence due to the narrow therapeutic window and significant adverse effects.[82] Lithium is generally associated with greater efficacy in the prevention of manic rather than depressive episode recurrences,[45,63] which is consistent with its predominantly antimanic effects in acute treatment. Divalproex has an efficacy equivalent to lithium for the prevention of recurrence,[83] while carbamazepine may be found to be more effective than lithium in patients with atypical features, such as mixed states and delusion.[63]

Acute pharmacologic treatment has the objective to reduce symptoms promptly with acceptable safety and tolerability. The treatment that is selected is based on the characteristics of the mood episode (ie, its polarity and symptom severity) and on the patient's general health status, including the presence of concurrent medical conditions such as diabetes or obesity, which can be exacerbated by certain therapies. A lack of response or an adverse effect to a medication may prompt a change in dose or a switch to another medication class. For many patients, particularly those with severe manic episodes or mixed states, combination therapy may be required—either using 2 or more medications concurrently or by the introduction of psychosocial approaches.[55-57]

Approximately 1 in 5 bipolar patients will eventually require 4 or more concomitant pharmacologic medications to control their symptoms.[58] High rates of comedication use are particularly common in patients with a high burden of depressive symptoms and at elevated risk for suicidality.[58] While combination therapy may provide greater symptom control, it is also associated with an increased burden of adverse effects, cost, and potential for drug-drug interactions.[59]

Acute Treatments

Manic symptoms. Established medications for the treatment of manic symptoms include lithium, divalproex, carbamazepine, and the atypical antipsychotics asenapine, aripiprazole, olanzapine, quetiapine, risperidone, and ziprasidone (Table 9).[51,60,61]

Lithium is a conventional mood stabilizer with a slower onset of action than the antipsychotics. The need to dose titrate lithium to reduce its toxicity also delays the time to achieve a response.[62] Lithium is associated with a moderate improvement in symptoms in 40%–80% of patients after 2 to 3 weeks of treatment for acute mania.[63] Lithium is one of the few medications that has been demonstrated to reduce the occurrence of suicide.[64] Divalproex and carbamazepine are at least as effective in reducing symptoms as lithium, with a faster onset of action.[63] More than one-half of patients treated with divalproex or carbamazepine experience significant improvement in their manic symptoms.[63]

Atypical antipsychotics have gained widespread acceptance as a first-line treatment in mania,[55] offering the advantage over typical antipsychotics of a reduced propensity to extrapyramidal adverse effects.[65] Each of the atypical antipsychotics has broadly similar efficacy in the treatment of acute mania, with response rates ranging from 49%–73% across different studies.[63] Trial evidence does point, however, to characteristic differences in the safety profile of these agents (discussed below).

Combination therapy for patients whose manic symptoms fail to respond to monotherapy frequently consists of a mood stabilizer (eg, lithium, divalproex, or carbamazepine) with an atypical antipsychotic.[45,66]

Depressive symptoms. When compared with mania, there are few medications with proven efficacy in the treatment of acute bipolar depression, particularly bipolar II depression. Quetiapine monotherapy, olanzapine in combination with fluoxetine, and (most recently) lurasidone monotherapy or in combination with lithium or valproate are the sole US Food and Drug

Once a bipolar diagnosis is established, the primary care physician can offer considerable practical support to both the patient and family, helping them to cope with daily life activities and to prepare for stressful life transitions such as moving away to college, entering the job market, marrying, and starting a family.

MANAGING THE BIPOLAR PATIENT IN PRIMARY CARE

Decision steps in bipolar management are summarized in Table 8.

Establishing a Care Pathway

Patients in danger of self-harm or of causing harm to others require immediate specialist psychiatric intervention, which may entail escorted transport from the primary care setting. The preparation of a management plan that specifies the current medications and other information relevant to the emergency services will assist the transition from primary to specialist care.

For other patients, primary care physicians should decide on the level of intervention that they wish to offer: whether providing acute and longer-term treatment themselves or involving specialist psychiatric intervention (through referral or as collaborative care) (Figure 1). The ability of a primary care physician to offer successful care to a bipolar patient depends on factors such as the severity of the condition, its complexity (including the presence of comorbidities), the wishes of the patient, the experience of the physician, and the organization of the practice team. It is the rare primary care physician who has the expertise, time, and resources available to manage bipolar I patients, particularly during their manic phases.

Organization of a practice team entails effective staff training and coordination, provision of patient-monitoring systems, and establishment of links to referral and support services.[49,50] A patient-centered, collaborative team approach that includes health care professionals with complementary skills offers the greatest likelihood of success.[49–52] This team typically includes nursing staff, community support workers, and specialist psychiatrics and psychologists, with the primary care physician taking a coordinating role at the center.[1,52] The primary care physician and psychiatrist should communicate frequently regarding any change in patient symptoms or functioning and should have an explicit understanding between them and with the patient regarding the management of medications. Because of the potential for drug-drug interactions with medications used for common comorbid medical conditions, both the psychiatrist and primary care physician should keep the other informed of any medication adjustments at the times they are being made.

Treatment Principles: Pharmacologic and Nonpharmacologic Treatments

For most patients, the foundation of acute and maintenance treatment is pharmacologic therapy.[53,54]

Family history can be highly informative for diagnosing bipolar disorder. Between 80% and 90% of bipolar patients describe family members with a history of mood disorders including bipolar disorder and MDD.[41] The children of bipolar patients are also at elevated risk (most studies suggest a 5%–15% risk[42,43]) of developing bipolar disorder,[44] indicating a strong genetic element in the predisposition to the condition. Of note, the "absent" parent or other relative—for instance, one who might have abandoned the family, been incarcerated, or was deceased when the current patient was a child—may, on further inquiry, be likely to have had a bipolar condition.

Other Elements of the Patient Interview

Physical examination. Physical examination cannot confirm a diagnosis of bipolar disorder, but it can, in combination with the medical history, help exclude the diagnosis by identifying illnesses that mimic bipolar symptoms.[2,33] For example, a physical examination may identify hypothyroidism or hyperthyroidism, which are associated respectively with depressive and manic symptoms.

Laboratory tests and imaging. No laboratory test is required to establish the diagnosis of bipolar disorder. However, in conjunction with the physical examination, laboratory tests can help to exclude alternative etiologies for mood symptoms.[2] Laboratory tests may include a urine toxicology screen (in cases in which substance misuse is suspected but denied) and a complete blood count (to exclude infection or anemia as potential causes of depression). Fasting glucose and lipid assessments are important for establishing the presence of diabetes or hyperlipidemia and for determining baseline values before initiation of treatment. MRI or other neuroimaging techniques are rarely indicated, but in selected cases can be valuable to exclude an organic etiology for mood symptoms, such as a brain tumor or multiple sclerosis in cases of recent-onset mania.[45]

Treatment response. A history of a lack of response to antidepressant monotherapies may suggest that a patient has bipolar disorder rather than MDD. Any patient who has experienced no symptom benefit from multiple trials of antidepressants should be reassessed for bipolar disorder. Conversely, patients who demonstrate a significant treatment response to antidepressant monotherapy or in whom the response is very rapid should be screened for possible precipitation of a manic/hypomanic episode.[46,47]

Differential diagnosis. A number of common psychiatric disorders may mimic the symptoms of bipolar disorder and should be considered in the differential diagnosis.[31] These disorders are summarized in Table 7.

The Family/Partner Interview

A history of the patient's symptoms obtained from a relative or close friend (with the patient's consent) can be highly informative, given that bipolar patients frequently lack insight into their own behavior and the effects of their behavior on others.[48] In other cases, the family will not be aware of the bipolar patient's condition.

other causes, including medical conditions, alcohol or drug abuse, or bereavement.[5] Of particular importance for patients who are experiencing depressive symptoms is to assess for risk of suicide and self-harm. The *DSM-5* provides guidance on the prominence to be given to suicide prevention in treatment planning for an individual with bipolar disorder.

The *DSM-5*-based criteria for diagnosing a bipolar depressive episode are identical to those for MDD,[5] and additional clinical features including past and concurrent symptoms are required for differential diagnosis (Figure 2). The depressive symptoms of bipolar disorder can also be attributed mistakenly to a number of other disorders, notably PTSD, anxiety disorders, schizoaffective disorder and schizophrenia, and personality disorders (Table 7).[14–16,30–34]

Confirmation of mixed features. The presence of depressive features during a manic episode or manic features during a depressive episode confirms the presence of mixed features.[5] Insomnia, agitation, appetite changes, psychotic features, and suicidal ideation are common presenting symptoms.[5] It is important to eliminate other potential causes of a mixed state, among which are antidepressant medications, electroconvulsive or light therapy, and medical treatments (eg, corticosteroids).

Patients who experience mixed episodes or features may, over time, progress to depressive-only episodes or, less frequently, to manic-only episodes.[5]

Functioning. Certain behaviors that are commonly associated with bipolar disorder can help to establish the diagnosis.[35] These behaviors may include instabilities related to the patient's family (eg, estrangement from the family of origin, divorce, frequent remarriage) or employment (frequent job changes, difficulties at work, unemployment), financial difficulties (bankruptcy, "boom and bust" cycles), or a history of impulsive or reckless behavior (sexually transmitted infections, unwanted pregnancies, substance abuse, accidents).

Understanding the severity and the type of functioning disorder can help to differentiate mania from hypomania. Disinhibition, poor judgment, risk-taking, and aggressive behaviors are all associated with a more severe, manic episode.[5,35]

Comorbidities. Patients with bipolar disorder are predisposed to other psychiatric disorders at elevated rates. Anxiety disorders (such as PTSD), personality disorder, ADHD, and alcohol or drug dependence are particularly common comorbidities.[36,37] The *DSM-5* acknowledges the clinical evidence that anxiety is an important modifier of bipolar prognosis by incorporating the disease specifier "anxious distress" in the diagnosis of bipolar disorder (Table 6).

Certain chronic physical conditions are also commonly found in the bipolar population, such as cardiovascular and metabolic disorders. Obesity, for example, affects about one-half of patients with bipolar disorder.[38] These conditions may in part reflect the lifestyle and behaviors associated with bipolar disorder, and they can significantly shorten life expectancy.[39,40]

Family History

In particular, the patient interview should establish[2,14]:

(1) The presence of past or current episodes of manic or depressive symptoms, as described for example in the *DSM-IV*, recently updated to *DSM-5* (Tables 2 and 3);
(2) The duration and severity of the episodes including the presence of suicidal or homicidal ideation;
(3) The impact of the episodes on functioning in work, social, and family roles;
(4) The presence of comorbidities (such as substance abuse, personality disorder, and anxiety disorder including PTSD);
(5) The history of treatments administered and the response to treatments;
(6) The family history.

Besides establishing the diagnosis, these characteristics are an important element of treatment planning, helping to select the optimal medication(s) and the site of treatment—whether in the primary care setting or involving specialist psychiatric support.

In cases of continued diagnostic uncertainty, the formal diagnosis of bipolar disorder may require a follow-up patient interview by an experienced primary care physician or psychiatrist to confirm the presence of *DSM-5* criteria, as well as to categorize the specific subtype of bipolar disorder that is present.[5]

Bipolar disorder is commonly divided into subtypes with distinct features, including I and II (Table 6). A classification of bipolar I disorder requires the presence of mania, while bipolar II disorder is distinguished by hypomania in combination with at least 1 major depressive episode.[5] Bipolar II disorder is more common than bipolar I, and the subtlety of the symptoms of hypomania may mean that bipolar II disorder is mistaken for MDD.[29] Clinical trials have historically focused more on the treatment of bipolar I than bipolar II disorder.

Confirmation of manic symptoms. The *DSM-5* criteria for mania or hypomania should be applied to all patients in whom a diagnosis of bipolar disorder is suspected or who provided a positive case-finding test (Table 2). *DSM-5* criteria (compared with *DSM-IV-TR*) emphasize the importance of increased activity and energy in addition to mood in confirming the presence of manic or hypomanic symptoms. Physicians should also ensure that the manic symptoms identified are not better accounted for by other causes, such as substance abuse, concurrent medications, or other medical etiologies.

A review of the lifetime occurrence of manic episodes may reveal an exacerbation of symptoms over time, from initially mild episodes of hypomania, to mania accompanied by delusions, to delirious mania characterized by marked intensification of symptoms and a loss of self-control. In other patients, the intensity of symptoms never passes beyond hypomania.

Confirmation of depressive symptoms. Depression is the presenting symptom of bipolar disorder in most patients.[10] *DSM-5* criteria specify that depressed mood and/or a loss of interest or pleasure must be present for at least 2 weeks, in combination with the symptoms itemized in Table 3.[5] Physicians should ensure that the depressive symptoms identified are not better explained by

Once a suspicion of bipolar disorder is raised, case-finding tools can offer a rapid assessment that helps to differentiate mood disorders (Figure 1). Case-finding tools cannot by themselves establish a bipolar diagnosis but are helpful in combination with the clinical interview (discussed below). A conflicting outcome from a case-finding tool and the interview may justify specialist consultation or referral.

Widely used instruments are the Mood Disorder Questionnaire (MDQ) and the Composite International Diagnostic Interview, version 3.0 (CIDI). The MDQ is a tool, completed by the patient, that includes 13 items to establish the presence of mood disorders and 2 questions to determine the level of functional impairment (Table 4).[22] If the patient endorses 7 or more of the 13 items, confirms that 2 or more symptoms occurred at the same time, and rates the functional impairment as moderate to severe, then the MDQ is considered positive. Many patients with bipolar disorder lack insight into their symptoms, so it can be informative to ask a family member or friend to complete the MDQ on the patient's behalf as well.

The CIDI is a structured interview performed by the physician.[23] A positive answer to 1 of 2 "stem questions" leads to 12 questions that are designed to identify manic symptoms (Table 5).[14,23] The more questions that are answered in the affirmative, the greater the likelihood of a positive diagnosis. As with the MDQ, the CIDI can be performed in a few minutes. Information and training are available on how to apply tools such as the MDQ and CIDI.[24,25] Both tools have been found useful in primary care practice.[14]

Recently introduced, Web-based case-finding tools include the My Mood Monitor (M3), which consists of 27 questions to screen for bipolar disorder, MDD, anxiety, posttraumatic stress disorder (PTSD), and substance abuse.[26] Questions in the M3 are designed to assess both symptoms and functioning.[27]

Electronic health record–based case findings represent another emerging technique.[28] A screening tool for bipolar disorder that is incorporated into the electronic health record is activated automatically when a patient presents with depressive symptoms. Typically, the patient's responses are recorded by a health care assistant for later assessment by the physician.[28]

While case-finding tools are valuable supportive measures, it is important to stress that none are infallible. These tools can help the clinician to recognize patients who are likely to have the diagnosis and can improve the efficiency of the clinical interview by identifying symptoms that the clinician should pursue during the interview. However, they are not diagnostic instruments and cannot be used in place of the patient interview.[14]

The Patient Interview

The detailed clinical interview formally establishes a diagnosis of bipolar disorder, based on a comprehensive history of past and current symptoms, augmented by medical records and family interviews (Figure 1). The clinical interview also can begin the process of educating the patient about the diagnosis and its impact.

(1) A history of mania or hypomania. This is the major differentiator of bipolar disorder from MDD (mania in bipolar I and hypomania in bipolar II disorder). All patients with depression should be questioned about current or prior manic or hypomanic symptoms (see Table 2). As discussed later, use of a bipolar screening tool in all patients diagnosed with a major depressive episode may represent a time-efficient practice routine as a first step, followed by a confirmatory clinical interview guided by the responses.
(2) Age at onset. The age at onset for bipolar depression is typically earlier than for MDD, with first symptoms often manifesting between the ages of 13 and 18 years.[17] By contrast, the symptoms of MDD first manifest, on average, in the mid- to late 20s.[18]
(3) Atypical features. Patients with bipolar disorder more often experience "atypical" features of depression, such as hypersomnia, hyperphagia, and rejection sensitivity, when compared with MDD. Mood lability, psychotic symptoms, psychomotor retardation, and pathological guilt are also more predictive of bipolar disorder.
(4) Course of illness. Bipolar disorder is characterized by more frequent and more rapid onset of recurrences than MDD. A history of frequently recurring depression, especially with melancholic or psychotic features, may be an indicator of bipolar disorder.
(5) Treatment history. A history of lack of response to antidepressants may point to a bipolar diagnosis. Antidepressant monotherapy may also increase the risk of rapidly "switching" a bipolar patient from a depressive to a manic episode.[19]
(6) Family history. A history of mood disorders in the family is a strong predictor for bipolar disorder.

Suspicion of mixed features. "Mixed features" is a new specifier in the *DSM-5*, which is added in place of "mixed episodes" in the *DSM-IV-TR*. Patients with concurrent manic and depressive symptoms may experience significant energy, impulsivity, and irritability in combination with depression and hopelessness.[5,20] The presence of mixed states is a particular danger to patients, because the combination of dysphoria, high energy, and decreased sleep places them at high risk for suicide.[21]

The *DSM-5* includes minimum duration criteria for bipolar I (7 days) and bipolar II (4 days) manic or hypomanic episodes, respectively.[5] These criteria are useful in a research context to identify patients with a high likelihood of these conditions. However, in clinical practice, patients frequently have episodes that do not meet these minimum duration criteria. The *DSM* classification of bipolar disorder not otherwise specified (NOS) may be used in such cases.[5] These criteria are retained in the recently published *DSM-5*, although NOS is changed to "not elsewhere defined." A new bipolar classification proposed by the *DSM-5* is "other specified bipolar and related disorders," which includes individuals with a past history of MDD who meet the criteria for hypomania except for the duration (hypomania requires at least 4 consecutive days of symptoms) or individuals with insufficient hypomanic symptoms to establish a bipolar II diagnosis (although the duration is at least 4 days). The division of bipolar disorder into subtypes is discussed in further detail elsewhere in this article.

The Role of Case-Finding Tools

This review recommends key decision-making steps in the management of patients with bipolar disorder—from the initial stages of clinical suspicion, to confirmation of the diagnosis, through acute and longer-term management and monitoring (Figure 1).

MAKING THE DIAGNOSIS OF BIPOLAR DISORDER

Decision steps in the diagnosis of bipolar disorder are summarized in Table 1.

When to Suspect Bipolar Disorder

Patients who first present to primary care with bipolar disorder may show a wide range of mood-related symptoms, including depression, anxiety, mood swings, irritability, fatigue, difficulty in sleeping, and inability to focus and concentrate. Certain psychiatric and medical comorbidities are also extremely common and, by their presence, raise a suspicion of bipolar disorder. The patient's social history will often show characteristic sequelae of the illness, such as relationship and marital problems, erratic occupational histories, financial troubles, and recurrent legal issues.

Diagnosing bipolar disorder in the face of the diverse symptoms and sequelae is a challenge that requires a high index of suspicion.

Suspicion of a manic episode. A full-blown manic episode that includes the cardinal symptoms may be readily identifiable in most patients with bipolar I disorder, but the symptomatology can be variable (Table 2). Particular attention should be paid to the symptomatology of mania in patients with comorbidities (eg, anxiety, panic disorder, substance abuse), as these symptoms can further complicate or mask the diagnosis. Patients experiencing a manic episode should receive urgent specialist investigation and treatment because of the high risk of harm to self or others. Manic episodes frequently require intensive outpatient treatment or admission to a psychiatric facility (including involuntary admission) to provide a safe environment during treatment induction.

Milder episodes of mania, such as hypomania, which is characteristic of bipolar II disorder, are more easily missed. For many patients, a hypomanic episode represents a period of "wellness" after an episode of depression, and they may not report hypomanic symptoms unless specifically questioned. These patients may even challenge their bipolar diagnosis. The provision of information in the form of written materials, recommended Web sites, and support group details can help these patients to accept their diagnosis.

Suspicion of a depressive episode. Depressive symptoms are experienced most frequently and for the longest duration in bipolar disorder, and are the most common reason for patients to seek care (Figure 1).[10–12]

The symptoms of depression in bipolar disorder closely resemble those in MDD,[5,13] and, so, it is recommended that every patient presenting with depression should be evaluated for bipolar disorder (Table 3). Patient characteristics that can help to differentiate bipolar depression and MDD are included below and in Figure 2.[14–16]

■ A thorough diagnostic evaluation at clinical interview, combined with supportive case-finding tools, is essential to reach an accurate diagnosis.

■ Pharmacologic treatment underpins both the short- and long-term management of bipolar disorder. Whichever treatment approach is selected, monitoring over the long-term is essential to ensure continued symptom relief, functioning, safety, adherence, and general medical health.

Primary care physicians are the first point of contact for many patients with bipolar disorder, and they have a fundamental role in the diagnosis and treatment of this lifelong condition.[1] The diversity of the potential symptoms in bipolar disorder may mean that the condition will remain unrecognized in many patients for several years. Making an inaccurate diagnosis—often of major depressive disorder (MDD)—also may be problematic, as it leads potentially to initiation of inappropriate treatment and a deterioration in symptoms.

Bipolar disorder is a chronic illness that is typically experienced first in early adulthood, although onset in childhood or in older age may also occur. Bipolar disorder can be divided into subtypes, including bipolar I and bipolar II disorder. Bipolar I disorder is distinguished by full-blown manic episodes that are more impairing than the hypomanic episodes that characterize bipolar II disorder. Depression, which is the presenting symptom of bipolar disorder in most patients, may impose a greater disease burden, in terms of both duration and impact, than manic symptoms. Depressive symptoms may be of similar severity in bipolar I and II disorder, and, therefore, bipolar II disorder should not be considered a "milder" illness than bipolar I. The form of the disease that individuals experience tends to be stable over their lifetime. For patients with either condition, the primary care physician can play an important role, often working with psychiatric consultants, in both managing treatment and monitoring the bipolar disorder and ensuring that other health care needs are met, including preventive care and managing chronic comorbid medical conditions.

Either a manic episode or a depressive episode may be the first presentation of bipolar disorder. The subsequent disease course is characterized by repeated manic or depressive episodes, which are separated by periods during which symptoms do not meet diagnostic criteria.[2] Even during these "euthymic" periods, patients may continue to experience some symptoms and decreased functioning,[3] and brain function continues to be abnormal on functional magnetic resonance imaging (MRI).[4] The timing of the recurrent mood episodes and their polarity (whether manic or depressive), duration, and severity are highly variable between patients and can also vary in the same patient over time. The symptoms typically have a severely debilitating impact on the patient's functioning, employment or educational prospects, and quality of life, and they can substantially elevate the risk of suicide, particularly during depressive episodes with or without mixed features.[2,5–7]

Early, accurate diagnosis can substantially reduce the burden of bipolar disorder and improve the long-term outcome for patients.[8,9] Establishing the diagnosis can, however, be problematic, given the diversity of symptoms that can suggest a number of alternative diagnoses. A high index of suspicion that the symptoms may indicate bipolar disorder is essential.

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The Diagnosis and Treatment of Bipolar Disorder: Decision-Making in Primary Care

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Ex. 5

Abstract

Bipolar disorder is a chronic episodic illness, characterized by recurrent episodes of manic or depressive symptoms. Patients with bipolar disorder frequently present first to primary care, but the diversity of the potential symptoms and a low index of suspicion among physicians can lead to misdiagnosis in many patients. Frequently, co-occurring psychiatric and medical conditions further complicate the differential diagnosis. A thorough diagnostic evaluation at clinical interview, combined with supportive case-finding tools, is essential to reach an accurate diagnosis. When treating bipolar patients, the primary care physician has an integral role in coordinating the multidisciplinary network. Pharmacologic treatment underpins both short- and long-term management of bipolar disorder. Maintenance treatment to prevent relapse is frequently founded on the same pharmacologic approaches that were effective in treating the acute symptoms. Regardless of the treatment approach that is selected, monitoring over the long term is essential to ensure continued symptom relief, functioning, safety, adherence, and general medical health. This article describes key decision-making steps in the management of bipolar disorder from the primary care perspective: from initial clinical suspicion to confirmation of the diagnosis to decision-making in acute and longer-term management and the importance of patient monitoring.

Clinical Points

- Patients with bipolar disorder frequently present to primary care, but the diversity of the potential symptoms and a low index of suspicion can lead to misdiagnosis in many patients.

- Inflated self-image
- Excessive spending
- Hypersexuality
- Substance abuse

People in manic episodes may spend money far beyond their means, have sex with people they wouldn't otherwise, or pursue grandiose, unrealistic plans. In severe manic episodes, a person loses touch with reality. They may become delusional and behave bizarrely.

Untreated, an episode of mania can last anywhere from a few days to several months. Most commonly, symptoms continue for a few weeks to a few months. Depression may follow shortly after, or not appear for weeks or months.

Many people with bipolar I disorder experience long periods without symptoms in between episodes. A minority has rapid-cycling symptoms of mania and depression, in which they may have distinct periods of mania or depression four or more times within a year. People can also have mood episodes with "mixed features," in which manic and depressive symptoms occur simultaneously, or may alternate from one pole to the other within the same day.

Depressive episodes in bipolar disorder are similar to "regular" clinical depression, with depressed mood, loss of pleasure, low energy and activity, feelings of guilt or worthlessness, and thoughts of suicide. Depressive symptoms of bipolar disorder can last weeks or months, but rarely longer than one year.

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What Are the Treatments for Bipolar I Disorder?

Manic episodes in bipolar I disorder require treatment with drugs, such as mood stabilizers and antipsychotics, and sometimes sedative-hypnotics which include benzodiazepines such as clonazepam (Klonopin) or lorazepam (Ativan).

Mood Stabilizers

Lithium (Eskalith, Lithobid): This simple metal in pill form is especially effective at controlling mania that involves classical euphoria rather than mixtures of mania and depression simultaneously. Lithium has been used for more than 60 years to treat bipolar disorder. Lithium can take weeks to work fully, making it better for maintenance treatment than for sudden manic episodes. Blood levels of lithium as well as tests to measure kidney and thyroid functioning must be monitored to avoid side effects.

Valproate (Depakote): This antiseizure medication also works to level out moods. It is faster acting than lithium for an acute episode of mania. It is also often used "off label" for prevention of new episodes. As a mood stabilizer that can be used by a "loading dose" method -- beginning at a very high dose -- valproate allows the possibility of significant improvement in mood as early as four to five days.

Bipolar I Disorder

Written by Matthew Hoffman, MD

Medically Reviewed by Smitha Bhandari, MD on August 14, 2022

IN THIS ARTICLE

What Is Bipolar I Disorder?

Bipolar I disorder (pronounced "bipolar one" and also known as manic-depressive disorder or manic depression) is a form of mental illness. A person affected by bipolar I disorder has had at least one manic episode in their life. A manic episode is a period of abnormally elevated or irritable mood and high energy, accompanied by abnormal behavior that disrupts life.

Most people with bipolar I disorder also suffer from episodes of depression. Often, there is a pattern of cycling between mania and depression. This is where the term "manic depression" comes from. In between episodes of mania and depression, many people with bipolar I disorder can live normal lives.

Who Is at Risk for Bipolar I Disorder?

Virtually anyone can develop bipolar I disorder. About 2.5% of the U.S. population suffers from bipolar disorder -- almost 6 million people.

Most people are in their teens or early 20s when symptoms of bipolar disorder first appear. Nearly everyone with bipolar I disorder develops it before age 50. People with an immediate family member who has bipolar are at higher risk.

What Are the Symptoms of Bipolar I Disorder?

During a manic episode in someone with bipolar disorder, elevated mood can manifest itself as either euphoria (feeling "high") or as irritability.

Abnormal behavior during manic episodes includes:

- Flying suddenly from one idea to the next
- Rapid, "pressured" (uninterruptible), and loud speech
- Increased energy, with hyperactivity and a decreased need for sleep

(3)

hopeless? Have you ever noticed your high-energy levels and racing thoughts suddenly turn to feelings of worthlessness and an inability to experience pleasure doing the same things you once enjoyed? If not, it's unlikely that you have bipolar disorder.

Several important features of bipolar disorder allow us to distinguish between the severe mental condition and the occasional mood swing. The first feature is whether the fluctuations in mood are caused by a situation, person, or event, or appear without cause. While the moods of people with bipolar disorder can be affected by situational variables, people with bipolar disorder also frequently become manic or depressed for no apparent reason. In comparison, for most people, moodiness is tied to a situational event, particularly stressful period, or even hormonal changes in the body.

The duration and intensity of high and low moods are also factors to consider when making a judgment on whether you should be concerned about bipolar disorder. Individuals with bipolar experience an elevated or irritable mood for at least four consecutive days, while their depressive episodes last for at least two weeks at a time. If you're struggling with moodiness, the intensity of the moods you are experiencing is likely significantly higher on the intensity scale than those of people with bipolar disorder.

If you're unsure about whether your mood swings are normal or could be symptomatic of bipolar disorder. You may want to start a mood diary using an app such as "Daylio" to help keep track and monitor your mood fluctuations. Psychologists and therapists suggest that this can be a therapeutic activity. It can also help you to determine whether events or situations in your life cause your mood swings or if they appear seemingly without cause.

If you are concerned about bipolar disorder, we encourage you to make an appointment with your doctor or mental health professional to discuss the specific details of your fluctuating mood.

Some other anti-seizure drugs, notably carbamazepine (Tegretol) and lamotrigine (Lamictal), can have value in treating or preventing manias or depressions. Other antiseizure medicines that are less well-established but still sometimes used experimentally for the treatment of bipolar disorder, such as oxcarbazepine (Trileptal).

Antipsychotics

For severe manic episodes, traditional antipsychotics (such as Haldol, Loxapine, or Thorazine) as well as newer antipsychotic drugs -- also called atypical antipsychotics -- may be necessary. Cariprazine (Vraylar) is a newly approved antipsychotic to treat manic or mixed episodes. Aripiprazole (Abilify), asenapine (Saphris), clozapine (Clozaril), lumateperone (Caplyta), olanzapine (Zyprexa), quetiapine (Seroquel), risperidone (Risperdal), and ziprasidone (Geodon) are often used, and many other drugs are available. The antipsychotic lurasidone (Latuda) is approved for use -- either alone or with lithium or valproate (Depakote) -- in cases of bipolar I depression. Antipsychotic medicines are also sometimes used for preventive treatment.

Benzodiazepines

This class of drugs, referred to as minor tranquilizers, includes alprazolam (Xanax), diazepam (Valium), and lorazepam (Ativan). They are sometimes used for short-term control of acute symptoms associated with mania such as agitation or insomnia, but they do not treat core mood symptoms such as euphoria or depression. They can also become habit-forming so need to be closely monitored.

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Antidepressants

Common antidepressants such as fluoxetine (Prozac), paroxetine (Paxil), and sertraline (Zoloft) have not been shown to be as effective for treating depression in bipolar I disorder as in unipolar depression. In a small percentage of people, they can also set off or worsen a manic episode in a person with bipolar disorder. However, studies have shown that for bipolar II depression, some antidepressants (such as Prozac and Zoloft) may be safe and more helpful than in bipolar I depression. For these reasons, the first-line treatments for depression in bipolar disorder involve medicines that have been shown to have antidepressant properties but also no known risk for causing or worsening mania. The five FDA-approved treatments for bipolar depression are lumateperone (Caplyta), lurasidone (Latuda), olanzapine-fluoxetine (Symbyax) combination, quetiapine (Seroquel) or quetiapine fumarate (Seroquel XR), and cariprazine (Vraylar). Other mood-stabilizing treatments that are sometimes recommended for treating acute bipolar depression include lithium, Depakote, and lamotrigine (Lamictal) (although none of these latter three medicines is FDA-approved specifically for bipolar depression). If these fail, after a few weeks a traditional antidepressant or other medicine may sometimes be added. Psychotherapy, such as cognitive-behavioral therapy, may also help.

People with bipolar I disorder (mania or depression) have a high risk for recurrences and usually are advised to take medicines on a continuous basis for prevention.

evaluation to assess the patient's symptoms in accordance with the specific criteria from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. To be diagnosed with bipolar disorder, a person must have experienced at least one episode of mania or hypomania.

To be considered mania, the elevated, expansive, or irritable mood must last for at least one week and be present most of the day, nearly every day. To be considered hypomania, the mood must last at least four consecutive days and be present most of the day, almost every day.

During this period, three or more of the following symptoms must be present and represent a significant change from usual behavior:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. Increased talkativeness
4. Racing thoughts
5. Distracted easily
6. Increase in goal-directed activity or psychomotor agitation
7. Engaging in activities that hold the potential for painful consequences, e.g., unrestrained buying sprees

The depressive side of bipolar disorder is characterized by a major depressive episode resulting in depressed mood or loss of interest or pleasure in life. The DSM-5 states that a person must experience five or more of the following symptoms in two weeks to be diagnosed with a major depressive episode:

1. Depressed mood most of the day, nearly every day
2. Loss of interest or pleasure in all, or almost all, activities
3. Significant weight loss or decrease or increase in appetite
4. Engaging in purposeless movements, such as pacing the room
5. Fatigue or loss of energy
6. Feelings of worthlessness or guilt
7. Diminished ability to think or concentrate, or indecisiveness
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt

Could My Mood Swings Be Bipolar Disorder?

We all have good and bad days –sometimes we feel on top of the world and other days, if we lose a job, go through a bad break-up, or fall out with a friend, we may be down in the dumps. But have you ever gone to bed one night feeling euphoric and woken up the next morning to find you feel empty and

What is Bipolar Disorder?

Bipolar disorders are described by the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5) as a group of brain disorders that cause extreme fluctuation in a person's mood, energy, and ability to function.

Bipolar disorder is a category that includes three different condition--bipolar I, bipolar II, and cyclothymic disorder.

- *Bipolar I disorder* is a manic-depressive disorder that can exist both with and without psychotic episodes
- *Bipolar II disorder* consists of depressive and manic episodes which alternate and are typically less severe and do not inhibit function
- *Cyclothymic disorder* is a cyclic disorder that causes brief episodes of hypomania and depression

Bipolar and related disorders are given a chapter of their own in the DSM-5, between depressive disorders and schizophrenia spectrum disorders. People who live with bipolar disorder experience periods of great excitement, overactivity, delusions, and euphoria (known as mania) and other periods of feeling sad and hopeless (known as depression). As such, the use of the word *bipolar* reflects this fluctuation between extreme highs and extreme lows. The diagnosis is frequently assigned to young patients presenting with a (first) major depressive episode. In these cases, diagnosis is exclusively based on psychiatric history provided by family and caregivers, not on the current psychopathological assessment by the psychiatrist.

Bipolar disorder occurs in up to 2.5% of the population, but the prevalence is much higher among first-degree relatives of individuals with bipolar or schizophrenia disorder. Individuals with bipolar disorder experience mood swings that are less severe in intensity. During what is known as a hypomanic episode, a person may experience elevated mood, increased self-esteem, and a decreased need for sleep. Unlike a manic episode, these symptoms are not so severe as to impact daily functioning or cause psychotic symptoms.

What's more, in some cases, a bipolar episode can include symptoms of both mania and depression; this is what's known as an episode with mixed features. People experiencing an episode with mixed features may feel extreme sadness, guilt, and worthlessness, while at the same experiencing high energy, racing thoughts and speech, and overactivity. It is not uncommon during a mixed episode for a person to go from being exuberantly happy to be expressing suicidal thoughts in a matter of moments.

Bipolar Disorder DSM-5 Diagnostic Criteria

Talking with a doctor or mental health professional is the first step in identifying bipolar disorder. Firstly, a doctor may perform a physical evaluation to rule out any other conditions that may be causing symptoms. If no other illnesses are present, the doctor will conduct a comprehensive mental health

Assignment 1A: Financial Analysis Snapshot and Initial Findings
Due Sunday, Midnight of Week 4 (10% of Final Grade)

Assignment 1 B: Executive Memo and Presentation
Due Sunday, Midnight of Week 5 (20% of Final Grade)

Your first assignment in this course will allow you to demonstrate your financial-statement-analysis skills. You will compare two real-life competitors and apply Variance Trend Analysis to their annual reports to find the "story behind the numbers." You will use the techniques covered in the first half of the course, which you have been exploring in the Discussion Questions for Weeks 2 through 4, so you should be well prepared to tackle this assignment.

You will be given the names of the two companies to compare, along with the specific assignment instructions in the Assignment module in Blackboard. Detailed rubrics for Assignments 1A and 1B will be provided in the assignment instructions documents. You will submit your work in the form of:

- Part A: Financial Analysis Snapshot and Initial Findings using data from the companies' annual reports
- Part B: Executive Memo and brief Video Presentation of your analysis

Assignment 2: Cost-Benefit Analysis
Due Sunday, Midnight of Week 9 (25% of Final Grade)

Your second assignment focuses on assessing the financial attractiveness of one or more capital investments. You will be provided with several scenarios, and you will use the Cost-Benefit Analysis techniques you have been learning about to calculate the Discounted Payback, Nominal Payback, Net Present Value, and Internal Rate of Return for a potential investment. You will also assess the nonfinancial elements of the investment and provide your recommendations on whether to pursue the project(s).

Detailed information on each scenario, along with specific questions to be answered, will be provided in the Assignment module in Blackboard. Detailed rubrics will be provided in the assignment instructions documents. You will submit your work in the form of:

- Part A: Data calculations based on the information in the scenarios
- Part B: Recommendations based on the calculations

GRADING SCALE – Graduate

Graded Activities	% of Grade
Discussion Questions (10 Total – one each week) Due: Initial post due by Midnight on Wednesday each week; responses to two student posts due by Midnight on Sunday of that week	25
Knowledge Checks (8 Total worth 2.5% each) Due: Sunday at Midnight of weeks 1, 2, 3, 4, 6, 7, 8, and 10	20
Assignment 1A: Financial Analysis Snapshot and Initial Findings Due: Sunday at Midnight of week 4	10
Assignment 1B: Executive Memo and Presentation Due: Sunday at Midnight of week 5	20
Assignment 2: Cost-Benefit Analysis Due: Sunday at Midnight of week 9	25
Total	**100%**

Week	Weekly Materials, Activities, and Assignments
10	**BUDGETING** **Learning Outcomes** • Learn key terminology and concepts associated with Budgeting • Explore the advantages and disadvantages of common approaches to budgeting…and Jack's BETTER approach • Apply managerial accounting practices in Budgeting and Forecasting to increase profitability and make better business decisions **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 12 • Additional Support Materials and Articles **Activities** • Discussion: *Budgeting* • Knowledge Check **Assignments** • None
11	**Activities** • Learning Journal

Week	Weekly Materials, Activities, and Assignments
9	**BUSINESS PLANNING and FORECASTING** **Learning Outcomes** • Learn key terms and concepts associated with Financial Forecasting • Understand concepts like CAGR to forecast risk level • Use data-based techniques to provide meaningful estimates of future financial results **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 11 • Additional Support Materials and Articles **Activities** • Discussion: *Forecasting and CBA* **Assignments** • Assignment 2: Cost-Benefit Analysis Due: Sunday, Midnight of Week 9

Week	Weekly Materials, Activities, and Assignments
8	**COST-BENEFIT ANALYSIS and CAPITAL BUDGETING** **Learning Objectives** • Learn key terms and concepts associated with Cost-Benefit Analysis • Discuss the role of financial and nonfinancial factors impacting the viability of business strategies • Apply tools and analysis techniques like NPV, IRR, and Payback to assess contribution **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 9 • Additional Support Materials and Articles **Activities** • Discussion: *Cost-Benefit Analysis* • Knowledge Check **Assignments** • None

Week	Weekly Materials, Activities, and Assignments
7	**COSTING SYSTEMS AND ANALYSIS** **Learning Outcomes** • Understand how costs are tracked and reported • Utilize managerial accounting terminology and concepts related to Cost Accounting • Apply analytical techniques such as Cost-Volume-Profit and Variance Analysis to make better business decisions **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 10 • Additional Support Materials and Articles **Activities** • Discussion: *Costing Systems and Analysis* • Knowledge Check **Assignments** • None

Week	Weekly Materials, Activities, and Assignments
6	**INTRODUCTION TO COST ACCOUNTING** **Learning Outcomes** • Understand managerial accounting terminology and concepts related to Cost Accounting • Identify key components of cost • Apply managerial accounting practices such as product costing and allocation choices **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 8 • Additional Support Materials and Articles **Activities** • Discussion: *Costs* • Knowledge Check **Assignments** • None

Week	Weekly Materials, Activities, and Assignments
5	**COMMUNICATION OF FINANCIAL RESULTS** **Learning Outcomes** • Listen to and discuss an earnings call from a publicly traded company • Utilize financial accounting terminology related to Financial Reporting • Examine the managerial responsibilities and implications of communicating financial information **Weekly Materials and Readings** • Additional Support Materials and Articles **Activities** • Discussion: *Earnings Call Review* **Assignments** • Assignment 1B: Executive Memo and Video Presentation Due: Sunday, Midnight of Week 5

Week	Weekly Materials, Activities, and Assignments
4	**THE CASH FLOW STATEMENT** **Learning Outcomes** • Utilize financial accounting terminology related to the Cash Flow Statement • Read, analyze, and draw conclusions from the Cash Flow Statement • Apply Variance Trend Analysis techniques to gain insight into changes in cash flow **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 5, and Ch. 6 • Additional Support Materials and Articles **Activities** • Discussion: *Cash Flow Statement Analysis* • Knowledge Check **Assignments** • Assignment 1A: Financial Analysis Snapshot and Initial Findings Due: Sunday, Midnight of Week 4

Week	Weekly Materials, Activities, and Assignments
3	**THE INCOME STATEMENT** **Learning Outcomes** • Utilize financial accounting terminology associated with the Income Statement • Read, analyze, and draw conclusions from the Income Statement • Apply Variance Trend Analysis techniques to gain insight into the Income Statement **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 4, and Ch. 7 (pp. 103 – 109) • Additional Support Materials and Articles **Activities** • Discussion: *Income Statement Analysis* • Knowledge Check **Assignments** • None

Week	Weekly Materials, Activities, and Assignments
2	**THE BALANCE SHEET** **Learning Outcomes** • Utilize financial accounting terminology related to the Balance Sheet • Read, analyze, and draw conclusions from the Balance Sheet • Apply Variance Trend Analysis to gain insight into the Balance Sheet **Weekly Materials and Readings** • Finance for Nonfinancial Managers, Ch. 3, and Ch. 7 (pp. 98 – 103) • Additional Support Materials and Articles **Activities** • Discussion: *Balance Sheet Analysis* • Knowledge Check **Assignments** • None

COURSE OUTLINE

This 4.5 credit-hour Masters-level course is designed with the goal of having each student spend 10-15 hours (13.5 hours on average) in weekly work. This includes preparation, activities, discussions, and assignments; live or online; individual or in groups.

Week	Weekly Materials, Activities, and Assignments
1	**THE LANGUAGE of BUSINESS** **Learning Outcomes** • Understand key financial accounting terminology and concepts, including Variance Trend Analysis • Explore the objective and process for recording business transactions • Identify the role, activities, and the value-add of the Finance and Accounting Departments **Weekly Materials and Readings** • The Real Life MBA, Ch. 5 • Finance for Nonfinancial Managers, Ch. 1, and Ch. 2 • Additional Support Materials and Articles **Activities** • Discussion: *Introduce Yourself* • Knowledge Check **Assignments** • None

Course Snapshot

Weekly Topics		Synopsis
FINANCIAL ACCOUNTING	1. The Language of Business	Our course begins with an examination of the roles that finance and financial professionals play in both for-profit and not-for-profit organizations. We discuss key terms, concepts, and principles within Financial Accounting and introduce Variance Trend Analysis – a key tool for decision-making.
	2. The Balance Sheet	The Balance Sheet is an accounting report used to track an organization's net worth. It summarizes the organization's assets, liabilities, and equity at a specific point in time and provides an overview of what the organization owns and owes, as well as the amount invested by owners.
	3. The Income Statement	This week we focus on the Income Statement. This report allows a comparison of revenues from the sale of products or services to the expenses incurred in the process of generating those revenues and is a key performance measure for companies and management.
	4. The Cash Flow Statement	In Week 4, we examine the last of the "Big Three" financial reports – The Cash Flow Statement. This report details where an organization's money is coming from and how it is being spent. This makes it one of the most critical resources in assessing the financial health of an organization.
	5. Communication of Financial Results	We conclude our study of Financial Accounting by examining the public communication of financial results as well as safeguards for protecting the integrity of financial information.
MANAGERIAL ACCOUNTING	6. Introduction to Cost Accounting	As we begin the second half of our course, we focus on essential management accounting concepts and techniques that will enable you to make winning business decisions. You will learn techniques for analyzing costs, isolating cost drivers, and evaluating alternative courses of action.
	7. Costing Systems and Analysis	This week, we examine systems that companies use to track, manage, and report costs. We also use Cost-Volume-Profit and Variance Analysis to understand cost trends and behaviors, and for guiding decisions to improve financial results.
	8. Cost-Benefit Analysis and Capital Budgeting	Demonstrating that potential investments will provide a positive economic payout is the first step in analyzing options, selling your ideas, and making strategic business decisions. This week, we focus on Cost-Benefit Analysis concepts and tools and explore the role of Capital Budging in developing an accurate picture of an investment.
	9. Business Planning and Forecasting	Forecasting is the act of predicting future financial outcomes. As the future is unknown, this task is both "art and science" and is an essential skill of every savvy manager. We will examine techniques to take some of the mystery out of the process and develop more accurate forecasts.
	10. Budgeting	Budgeting is a process far too many people dread. However, with Jack's approach, it is an opportunity for management to gain insight into new ideas, improve communication of expectations, and set a strategic direction backed by appropriate resources.

COURSE LEARNING OUTCOMES

1. Utilize financial accounting terminology to communicate effectively and professionally.
2. Read, analyze, and draw conclusions from the three main financial statements: the balance sheet, the income statement, and the statement of cash flows.
3. Apply Variance Trend Analysis techniques to gain insight into financial statements.
4. Analyze financial data and reports to make informed, strategic business decisions.
5. Apply managerial accounting practices such as product costing, capital budgeting, and cost/benefit analysis to increase profitability and make better business decisions.
6. Collect, synthesize, and apply financial accounting concepts and techniques to further financial acumen.

CONTACT INFORMATION FOR PROBLEMS OR ISSUES

- Have a curriculum-related question? Contact your instructor for assistance.
- Have a technology-related question? Contact JWMI Tech Support at (888) 596-5964 x3 or techsupport@jwmi.com.
- Have a student services-related question? Contact Student Services at (703) 561-2128 or stusupport@jwmi.com.

INSTRUCTIONAL MATERIALS

Required Resources

- Siciliano G. (2014). *Finance for Nonfinancial Managers*, 2nd edition. McGraw Hill Education, ISBN: 978-0-07-182436-1.
- Welch, J. & Welch, S. (2015). *The Real-Life MBA*. HarperCollins, ISBN: 978-0-06-236280-3.

Additional Resources (provided within the course)

- Videos
- Financial Statement Reference Guides
- Key Financial Ratios and Definitions
- Business Articles and Other Tools

NOTE: Some of the videos contained in this course are provided by LinkedIn Learning. We are fortunate to have free access to this wonderful resource for all students currently enrolled at JWMI. To access these videos, follow the steps here.

To help ensure the topics we cover make sense and that you come out of the course with tools you can use, we will leverage three primary types of activities that, together, will comprise your final grade:

1. **Knowledge Checks:** In Finance and Accounting, there are some essential facts that you just need to know. There is a right and a wrong answer when performing calculations. To help ensure you pick up the key concepts correctly, there is a short Knowledge Check quiz in eight weeks of the course; we do not have a Knowledge Check in weeks 5 and 9. These are designed to help you review what you have learned and ensure you understand the key concepts. Although they are graded, each Knowledge Check is only worth 2.5% of your total course grade, so you should approach these as learning opportunities and not as "high-stakes tests." You can take each Knowledge Check twice and use your notes, readings, and the Internet.

2. **Assignments**: You have TWO major assignments in this course, one aligned with Financial Accounting and one with Management Accounting. The assignments provide an opportunity to dive into analysis and apply your newfound skills to real-life scenarios. Each assignment is organized into Part A and Part B deliverables. The required readings, supplemental materials, videos, and "Success Sessions" from your professors are provided to help ensure your success.

3. **Discussion Questions**: The weekly discussion questions are designed to help you explore the topics covered that week. These questions allow you to develop and share your financial skills as you engage with your fellow students and your professor. Take full advantage of this and be engaged. As with most lessons, the more you put into it, the more you will get out of it.

YOUR ROLE IN THE COURSE

As in previous JWMI courses, you should approach this course through the lens of a senior business leader who runs a division or team and has responsibilities for the sound financial management of that entity.

Although this is a finance course, we will not spend the entirety of the ten weeks crunching numbers and doing math. Instead, we will focus on *what those numbers mean* and on *how to develop (and manage) financial strategies*. We have provided numerous resources to support your learning journey, and, of course, your professor is available for help as needed. In short, do not sweat the math! If you can add and subtract (and occasionally multiply and divide), you already have the math skills necessary to succeed in this course and in business.

As long as you are interested in the "big picture" of what the numbers really mean and have the willingness to do the work, this course will be a positive experience. Whether or not you aspire to a senior role in finance, this course will help you crack the code of financial lingo, learn to read financial reports, and apply sound financial management practices to help your business win.

Patriot's Ex. 2

JWI 530: Financial Management I
Course Guide

MISSION

The mission of *JWI 530: Financial Management I* is to transform lives and banish any "fear of finance" by building fluency in the language of business so students can use financial data, concepts, reports, and analytical techniques to drive better business results in current and in future roles.

COURSE DESCRIPTION

Financial accounting is often spoken of as the "language of business." Leaders must develop fluency in financial concepts, principles, and tools to understand and drive effective business decisions. In this course, you will learn to read, understand, and analyze financial data as recorded and reported in financial records and statements. You will also learn to apply concepts such as cost management, variance analysis, financial forecasting, and capital budgeting. Maximize the impact of your financial decisions by learning to speak with numbers.

COURSE OVERVIEW

The course is organized around two core areas:

1. Financial Accounting – how financial transactions are categorized, recorded, and reported. This section of the course will help you understand the conventions of Generally Accepted Accounting Principles (GAAP) and will teach you how to read and use the main financial reports and statements used by organizations around the world.

2. Management Accounting – how managers use the tools of budgeting, forecasting, and control to run their businesses. The second half of the course will take the mystery out of product costing reports, financial forecasting, and the budgeting process by explaining the financial terms and processes managers need to understand to run day-to-day operations. In addition, we will focus on how businesses assess the financial attractiveness of large-scale investments such as buying equipment or launching new ventures using Cost-Benefit Analysis techniques like NPV, IRR, and Payback.

119 B/S

OUR APPROACH

We approach the study of Financial Management in this course from a practical perspective that is designed to be applicable to all students. Our goal is to empower business leaders with the tools they need to be more effective. We will take the mystery and fear out of finance, presenting concepts in clear and direct ways. You will find lots of videos and hands-on exercises, texts, articles, and other materials that focus on the practical application of what you are learning.

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